

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XVII

December 1921

No. 6

A CHRISTMAS ROSE

By EDITH LIVINGSTON SMITH, LYNDEBOROUGH, N. H.



I WANT a set o' dishes," said black-haired Mary with emphasis, "'n a picture book, 'n a doll carriage, 'n a toy cook stove, 'n a puzzle, 'n——"

"You can't have so many things," chimed in Louise with a subdued stamp of her crutch and a look towards the head nurse's desk; "it's no fairs. Nurse said choose something you want more'n anything." "A doll, breathed round-eyed Dorothy softly, twisting her wisp of a braid round and round her finger, "a doll with yellow curls, and brown eyes that open and shuf, and shoes that button and come off."

"A watch that ticks minutes and pulses," called Sally from the third bed down.



"Seconds, you silly Sally," Louise corrected with withering superiority, "an' you can't take pulses 'cause you aint a nurse or a doctor."

"I mean 'seconds of course," Sally said blushing, "but I'm going to be a nurse when I grow up, so there now, Louise Dutton, you don't know everything."

It lacked only four days to Christmas and the girls' surgical ward in the B—Children's Hospital was the scene of

the above conversation, for the head nurse had said that she was going to make a list of names of the children that very afternoon, and would also write down the gift that each one would like to have on the Christmas tree.

Most of the children in bed were smiling with

the consciousness of a decision carefully considered, but a few were still hovering over an embarrassment of desire, while the little patients who were on crutches or in wheeled chairs went up and down the ward offering to these doubtful ones sympathetic attention and emphatic advice.

Louise, being the oldest girl in the ward, 'most eleven, had made herself mistress of ceremonies and arbiter of disputes, with an authority unquestioned by the others, for couldn't she run on crutches (when she was home), and hadn't she been in the hospital one other Christmas, two years before, and could, therefore, turn conjecture into delightful certainty.

There would be wreaths or holly bouquets for the windows. Louise had said so. There would be chicken for dinner and a Christmas tree for every ward. Louise had said so.

"You can ask for anything you want," declared Louise, "and probably, most likely, if the superintendent and the lady managers and Santa Claus have it in stock you'll get it." (Oh, tactful Louise!)

It was all very wonderful and even the nurses were excited and happy about Christmas coming so soon. At night if you weren't too sleepy and listened sharply when the swinging doors opened and shut you could hear far-away music—that was the nurses practising carols in the nurses' home, though little Rose said "maybe it was angels."

Little Rose was in the bed nearest the nurse's desk. She was sitting up with a bed rest, her cheeks as pink as her hospital jacket, her blue eyes alight with the excitement of the subject in hand.

She had hoped the others would forget about her. She hoped it hard as she pinched the bed spread into a little pattern, but Mary and Louise were swinging down her way on their crutches and Elizabeth, in the next bed, said in a voice that all could hear: "What do you want, Little Rose?"

The nurses did not know why the children called her "Little Rose," for she was seven years old and larger than some of the others in the ward. It may have been because her face was pinched and her eyes so big; it may have been because her voice was low and musical; or it may have been because she was "different" in a wistful, fragile way. It could not have been because of pity, for the children did not know why she was different. On second thoughts, though, it may have been pity, for it would seem as if intuition tells children many intangible things that wisdom cannot explain. At any rate she was "Little Rose" from the moment she had entered the ward two weeks before.

"Oh yes, what do you want?" echoed Mary.

The nurse at the desk looked up to hear the answer.

"Nothing," said Rose shyly.

"Nothing!" shrieked Elizabeth. "She can't choose nothing, can she, Miss Warren?"

"Nobody never wants nothing," announced Mary in horrified tones and horrible English.

"Choose something, Little Rose," said Louise gently. "I'll help you."

"I've chose," said Rose with a scared look at Miss Warren. "It's a secret."

"Oh dear!" wailed Elizabeth. "She can't have a *secret* about wishing for a present, cause folks won't know. That's an awful silly wish ain't it, Miss Warren?"

"No, no," Miss Warren said with a quick glance at the thin troubled face. "Perhaps Rose doesn't want to talk about her gift now, but she'll whisper what she wants to Miss Homers when she comes, won't you honey, and then it will be all right."

But later, when the head nurse wrote down the names of the children with the "wishes" carefully recorded, she started and her pencil hovered in mid-air as Rose whispered "the secret."

"I want one dreadful, Nurse," she pleaded. "All the other children have them. The city's awful big, don't you 'spose someone could find a—a stray one for me, maybe?" Her lips trembled.

As Miss Homers did not answer, she went on in a low voice, "If I can't have that, I guess I want a baby doll. Please can I make both chooses?"

"Yes, of course, child," Miss Homers said hurriedly. "See, I have written them down."

She could think of nothing else to say.

* * *

In all the rush and excitement of Christmas preparation there was much talk of Rose's gift.

Miss Homers had hastened to the superintendent with the red book and together they sought Miss Jennings, the social worker.

"The poor little thing," said Miss Jennings.

"She is a very unusual child," said Miss Homers eagerly.

"We have never done such a thing before," said the superintendent thoughtfully, "but that is probably because we have neglected our opportunities. Between us all, with all the good friends of this hospital, it would seem as if the lady managers or some of us could find a 'stray one' as a gift for Little Rose. If you will both help me this evening we will send postscript letters by special delivery to all whom we have asked to the Christmas festivities. There isn't much time, unfortunately."

"But miracles take no time at all," said Miss

Jennings, her eyes shining, "and I love to believe in miracles at Christmas!"

This was the note, received by all the lady managers, the wives of the trustees, and other special friends of the hospital:

"I am sending a hurried postscript to each guest who has been asked to attend the Christmas Tree festivities at the hospital to ask help in regard to one of the patients in the surgical ward. The child's name is Rose Jackson; the other children call her 'Little Rose.' She is seven years old, a lovely child with brown hair and blue eyes, an imaginative mind and a lovable personality. She is recovering from an operation for appendicitis and is otherwise healthy, except that she is thin from undernourishment. She was sent into the hospital as an emergency case by a kind neighbor who had taken her into her home after Rose's grandmother died. This neighbor has a large family of her own and Rose has no relatives as far as she knows.

"As the child is homeless, she was to have been turned over to the state or some charitable institution when able to leave the hospital, but circumstances have arisen which make us feel that we should take a different course. I hope you will agree with me that it is our privilege to find a home for Rose to go to when she leaves the hospital. If any one of you knows of anyone who wishes to adopt a child this is a wonderful opportunity, and I hope such a person will communicate with me quickly. It must be a real home in every sense of the word, for the gift that Rose has asked for for Christmas is—A MOTHER."

* * *

"Oh, come all ye faithful, joyful and triumphant," sang the nurses.

Never had there been such a happy Christmas in the B— Hospital. Never before were trees more gayly decorated or as heavily weighted with delight for childish hearts; never were sick children so merry, or ministering nurses more thankful of their calling. In all the wards supply and demand kept pace with the Christmas lists in a way which demonstrated happily that the words, for once, could be synonymous.

In the girls surgical ward the children were so excited with their gifts they did not notice that the visitors around the tree watched Little Rose with more than ordinary interest as she received a baby doll from the tree and cuddled it beside her in her wheeled chair.

Then, without words, for there seemed to be an undercurrent of understanding, the superin-

tendent and Miss Jennings went into the sun room, followed by an eager, sweet-faced woman, and Miss Homers pushed Rose's wheeled chair into the sun room also, and shut the door.

"This is Mrs. Morrison, Rose," the superintendent said—"a friend of the hospital whom I have known a long time. She loves children very much. You remember you told Miss Homers a secret,—that you want a mother for Christmas,—and if you hadn't said that I would never have known Mrs. Morrison had a secret wish, too—she wants a little daughter. So now you will each have what you need for happiness."

* * *

"How silently, how silently, the wondrous gift is given," the nurses were singing as they started towards the medical wards, "so God imparts to human hearts the blessings of His Heaven."

The glass doors of the sun room opened and shut again, softly, and Rose and her mother were left alone.

* * *

"I wonder how many other lonely women there are in this city," Mrs. Morrison said to the superintendent as she said good-bye to her a few minutes later, "who could be made happy by the promise of a Christmas Rose, and how many wistful children there are in hospitals and orphan homes who want a mother for a gift?"

"God knows, there must be many," said the superintendent.

* * *

The ward was darkened. Rose held her doll very close to her. She had begged to keep it "just this very night" and the night nurse, who knew the "miracle," as Miss Jennings called the outcome of Rose's secret, had somehow forgotten the hospital rules. Now she stooped over Rose's bed to hear what the child was saying in a sleepy voice—

"I'm going to name you after me, Dolly. I'm your mother and I'm going to have one, too. I didn't truly think I'd get any present only you, but I prayed to God for a mother and I asked the head nurse, and I wished on a star through the window. Perhaps, maybe, it was the Star of Bethlehem.

"Good-night Rose-bud. In a week we're going HOME."



THE ORGANIZATION OF THE ORTHOPEDIC SERVICE AT THE STATE UNIVERSITY OF IOWA

BY ARTHUR STEINDLER, M.D., F.A.C.S., PROFESSOR OF ORTHOPEDIC SURGERY, AND MAME ROSE PROSSER, M.A., PRINCIPAL OF THE UNIVERSITY HOSPITAL SCHOOL, IOWA CITY, IOWA

THE free medical work of the State University of Iowa is largely based upon legislation. Its foundation is the Perkins Act of 1915, amended by the Haskell-Klaus Act of 1919. These acts provide treatment and care at state expense for any resident of Iowa who is afflicted with some deformity or is suffering from some malady that can probably be remedied, provided the person or his lawful guardians are unable to provide such treatment and care. Under the provisions of these two acts about ninety per cent of the patients of the orthopedic service are admitted to the hospital.

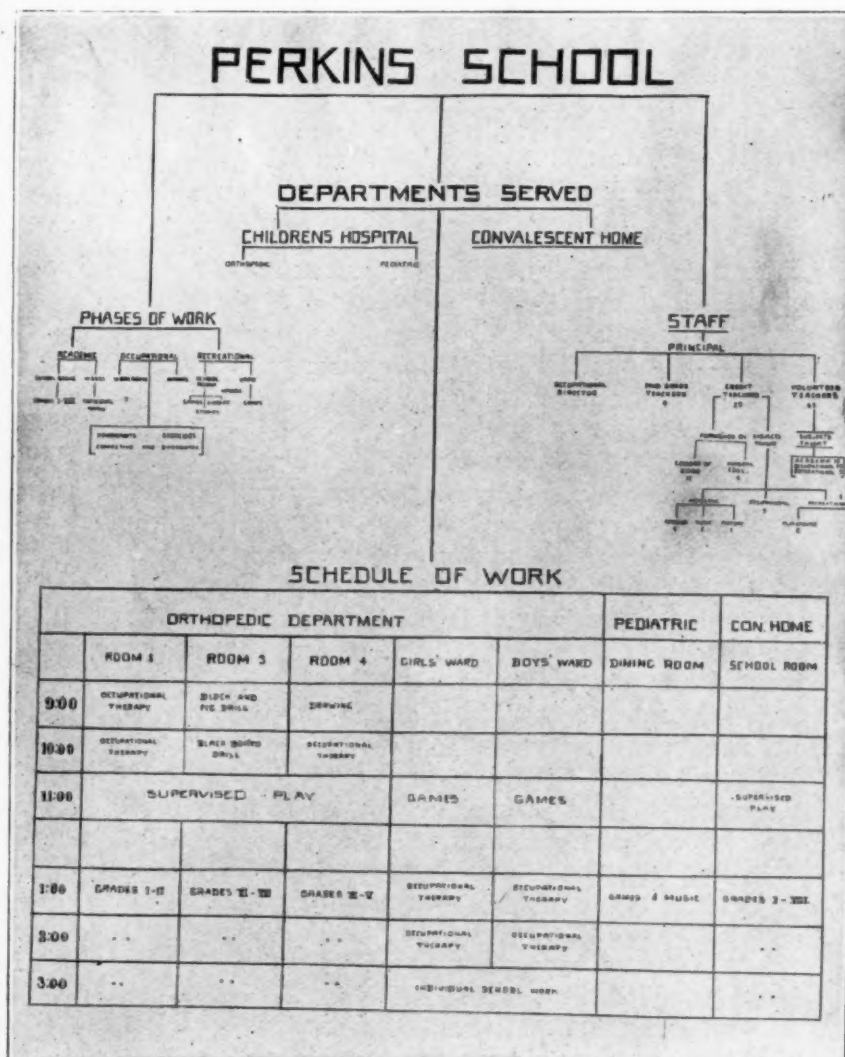
The organization of an orthopedic center from its very nature is a matter of considerable complexity. The two great and fundamental divisions of the service are the physical and the mental, the restoration of normal physical conditions; and the development of desirable social and educational conditions. The task of organizing an orthopedic service subservient to all the needs of the patient is fraught with much difficulty and labor. In the six years of its existence the service at the University of Iowa has initiated practically all of the desirable phases involved in such an undertaking. Some branches of the work are, by force of circumstances, much less advanced than others.

The intimacy of the relationship between the physical and the mental aspects of orthopedic work varies with the stage of treatment and the nature of the disability. Both should be directed by the chief surgeon through heads of departments who have a clear idea of the ultimate result desired, and who co-operate cheerfully and intelligently to secure that result. In some phases of the work the physical result desired can be obtained without active cooperation on the part of the patient so that educational aid is not required;

in other phases of the work, the educational procedure is modified but slightly by the physical condition of the patient. There are some forms of treatment, however, in which educational methods enter decidedly into the question of physical help. This is true in regard to muscle education and occupational therapy.

The physical aspect of the work at the University Hospital is provided for by the surgical staff and the nursing staff with their attendant orderlies, helpers, and nurse maids. Under the supervision of the surgical staff are the departments of mechano-therapy and occupational therapy, and the orthopedic workshop.

The educational work provided is under the supervision of the College of Education. It consists



Schedule of the organization of school and occupational work

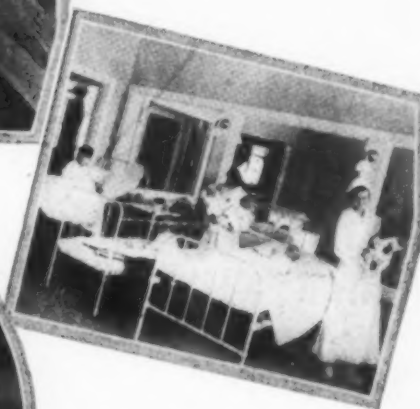
SCENES IN THE CHILDREN'S HOSPITAL AT THE UNIVERSITY OF IOWA



Crippled children at school



A machine for every muscle—the orthopedic gymnasium, a unique feature which is run in conjunction with the orthopedic clinic.



A room of the baby ward, where pure democracy reigns. The babies do not draw race distinctions. The white and colored babies enjoy equal rights.



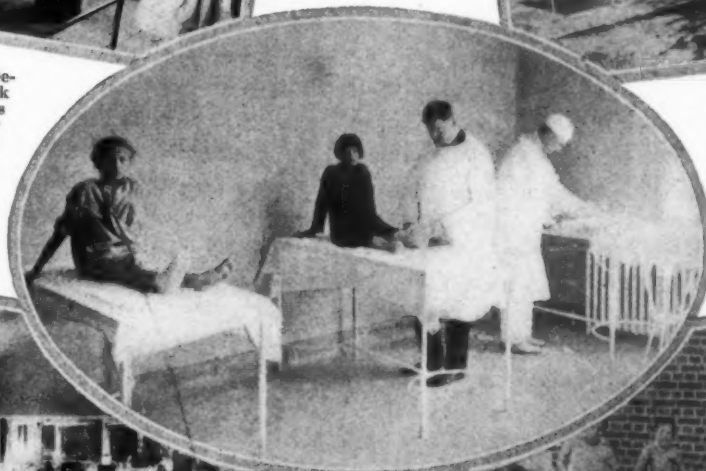
Studying speech defects with the aid of the dictaphone in the Child Welfare Research Station.



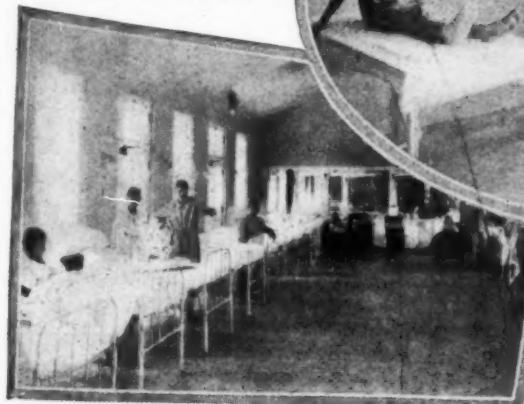
The milk laboratory in the Department of Pediatrics. The milk used in the children's hospital is tested every day. The laboratory diet kitchen, which is provided with a separator, a specially constructed pasteurizer, pressure cooker, sterilizer, fat tester, and other appliances. Every possible modification of milk may be obtained.



Above—a sun bath on the porch of the girls' ward. Below, at left—interior of the girls' ward in the Orthopedic Department. Below, at right—porch of the boys' ward at the recreation hour. Every face wears a smile, for the spirit of cheerfulness is all-pervading at the Children's Hospital.



Examining casts in the plaster cast room. The most interesting feature of the medical extension project at the university is the work done for children.



of the work of the first eight grades and tutoring in high school subjects where conditions warrant such work. As at present organized, the work in muscle training and occupational therapy is under the direction of the principal of the school.

Of the subdivisions of the service the orthopedic workshop, and the departments of mechanotherapy and occupational therapy, and the school work demand some detailed description.

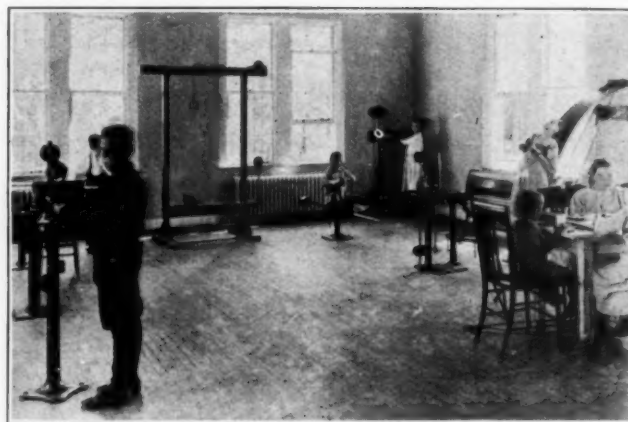
Equipment. In order to make the work of the shop fit into many of the exigencies of orthopedic work, it must be complete in its equipment even though the amount of its output is small. By this is meant that all phases of apparatus technique should be provided for—the steel work as well as the leather work, the sewing as well as the finishing, fitting, and designing. A satisfactory workshop has been planned and equipped as follows: The machinery for the steel room consists of one thirteen-inch South Bend lathe; one miller; one drill press; one throatless shears; one hand steel cutting shears; one power hammer; one blacksmith forge; one gas welding forge; two sets of polishing heads; one for steel grinding and polishing, and the other for leather polishing. This machinery is driven by two motors, one one-half and three horsepower.

The leather room is supplied with one shoemaker's jack, one leather sewing machine, and one ordinary sewing machine. In addition there are benches for leather and steel work as well as all the tools needed by the mechanic and the leather workers.

Personnel. The shop is managed by the foreman under the direction of the physician in charge and his first assistant. The foreman, who is an experienced leather worker with some experience in steel working, designs and fits all braces in accordance with directions and sketches submitted by the medical staff. Under his supervision a mechanic does the steel work with the help of an assistant. The latter divides his time between leather work and steel work. Two women helpers assist in lining, sewing, and finishing the braces.

A good mechanic is very essential for the output of well made hinges and other precision work such as automatic locks, special hinges, and the frame work of steel and leather braces. He is also employed to make specially designed surgical instruments such as chisels and files for bone work and arthroplasties.

Output. The annual output of the orthopedic shop is approximately two thousand orders which are about evenly divided between shoe and brace work. We believe that it is a distinct advantage to have experienced shoe workers employed in the shop and it is our policy to give the men who



In the gymnasium little equipment is required, for mechanotherapy is applied by the hands of experienced individuals rather than by machinery.

enter this line of work training in both orthopedic shoe work and orthopedic brace work.

One of the great problems in connection with the work has been the establishment of cost prices involving material used, deterioration of machinery, and labor. In order to come to exact figures, it is necessary to keep accurate accounts of time and material with each order put out. This is naturally a very tedious and time-consuming procedure and consequently has not been put into effect at the university orthopedic shop. But, from the approximate figures arrived at, there is reason to believe that such a shop could be conducted in state institutions as a self-supporting enterprise, with the prices for the work ranging a good deal below the commercial prices, provided that there is a thoroughly efficient management, especially in regard to the following points: (1) The purchase of leather, steel, and other material by an expert buyer; and (2) The distribution of the work in such a way that there is never an undue rush and never a slack of work. In the life of a rather active clinic, it is naturally very difficult to arrange the work in the shop so that the amount of work proceeds uniformly month after month, but it can be regulated to quite a degree by the medical staff which issues the orders for all work done in the shop. In the first place all orders should be issued by one man, the chief of staff or his assistant. Allowing a greater number of persons to issue orders is studiously to be avoided. The orders are issued on duplicate cards with the date carefully noted, and those which permit delay are dated in the future according to advice received from the foreman of the shop who knows how to distribute the work. It is the policy, however, not to allow more than two weeks to pass between the making of the model for a brace and the fitting of the brace. A certain part of the time is always kept open for emergency work which is constantly coming in from the out-patient clinic. This is mainly

shoe work, brace alterations and brace repair.

The orthopedic gymnasium is one of the fundamental institutions in orthopedic service and one upon which devolves especially the responsibility for after treatment.

Equipment. The surgeon in charge is a strong believer in the application of mechano-therapy by the hands of experienced individuals rather than by machinery. Consequently the equipment of the gymnasium has been reduced to a few types of medico-mechanical machinery, and there is a small number of Zander machines for the development of passive motion of the elbow, shoulder, wrist, knee, and ankle. The following standard forms of apparatus are also used: ladder, stall bars, pipe stalls, quarter circle, and wrist roll. In addition several smaller pieces of apparatus of our own construction are used in the measurement of the range of motion in different joints as well as for the development of certain motions of the fingers and wrists.

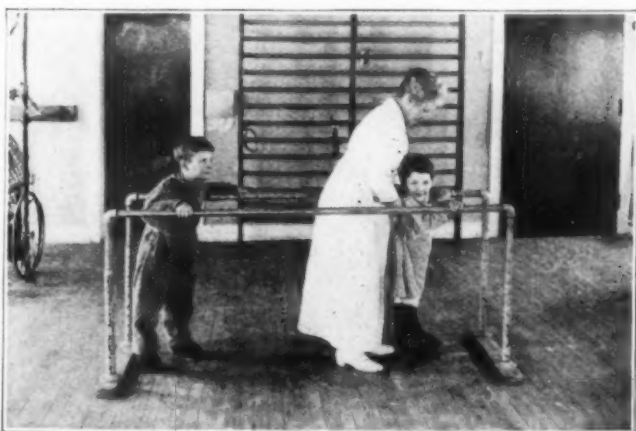
For the development of the gait, there is used a walking rail consisting of two long parallel bars which can be adjusted at different heights.

The Physiotherapists. The gymnasium is in charge of a first physiotherapist, a second physiotherapist, and a helper. The first two are graduates from normal schools of physical training, and the helper has been trained in this gymnasium for her part of the work. In addition to these, there are plans made to accept eight seniors from the University department of physical education into this teaching staff who will work for credit and will be assigned certain duties under the supervision of the physiotherapists.

The Patients. The average number of patients treated varies from thirty to sixty a day; the yearly number of treatments being between 8,000 and 10,000.

The Schedule. The work is conducted in classes arranged as follows:

- (1) The scoliosis and posture class having two



The walking rail, consisting of two parallel bars, which can be adjusted in height, is used for the development of the gait

daily sittings of one hour to one and one-half hours each. For the purpose of better supervision, this class is divided into: (a) postural cases, (b) cases of incipient scoliosis, (c) class of structural scoliosis. All cases receive massage treatment individually; the corrective exercises are carried out in class.

- (2) The so-called spastic class in which cases of spastic paralysis are given treatment, massage, and exercises, having two daily sittings of one hour each.

- (3) The hand classes for the mechanical treatment of deformities of hand and upper extremity. Although the patients appear in class, the supervision is practically individual; according to the needs, one-half to one hour to each patient daily. Most of the cases are referred for longer daily sittings to the class of muscle education, which is a subdivision of occupational therapy and will be discussed later.

- (4) A general class consisting of the rest of the material presenting itself for medico-mechanical treatment. To this belong cases of congenital dislocation of the hip, just out of cast, static conditions such as flat feet, and other conditions.

- (5) The joint class for the development of motion in afflicted joints. This work is done on no definite schedule, the larger part of it being done at the bedside.

Bedside Work. The bedside work of mechano-therapy is an important part of the work. It comprises:

- (1) The general massage treatment prescribed for bed patients for improvement of general condition.

- (2) Local massage of joints and muscles in cases of arthritis and other inflammatory conditions or in cases having undergone long fixation.

- (3) The treatment of arthroplasties and constructive work of the upper extremity in the first phase, consisting of the application of active motion and massage.

This work is so organized that one of the physiotherapists spends part of the day at the bedside, usually two to three hours. This phase of the work is out of all routine and the cases are very strongly individualized, the treatment varying in time from a few minutes to half an hour.

The Instructional Work. It has become very necessary in the course of the treatment to pay a good deal of attention to instructing the parents as far as possible in the work of medico-mechanics in order to secure the after-treatment at home. It is impossible in this institution, where the number of patients on leave throughout the state is many times the number of patients that can be accommodated in the hospital, to discharge patients without making some provision for the

continuance of the after-treatment at home. We have found the greatest difficulty in securing such after-treatment and we had to resort to the expedient of instructing the parents as best we could. We believe in many cases that this is entirely feasible and satisfactory; the parents are required to stay in town and witness the treatment for a period varying from a few days to a few weeks. Stress is laid on explaining to them the essential phases of the treatment. As far as active and passive exercises are concerned, we have found no difficulties if the parents were intelligent and willing to learn. Application of skillful massage under these conditions is out of the question; we feel very strongly that here is a great field to be covered. Possibly the solution will lie in the education of field nurses in massage or the development of field masseuses who can be trained in institutions and sent out to continue the work. Here is a great opportunity for the public health service to branch out into the work of physiotherapy.

This department serves two distinct types of cases, those who are assigned to it for designated curative forms of work, and those for whom the value of the work lies in its recreational and educational phases.

For the first class, the work, being entirely therapeutic, is placed under the control and direction of the medical staff. The course consists of muscle education and craft work.

The second class is given craft work and gardening, and is also provided with supervised play and library service. In this branch of the work the medical staff acts as advisor only.

Teachers. At present the department of occupational therapy is directed by the principal of the hospital school. Her assistant is a graduate of the Chicago Art Institute and of the Henry B. Favill School of Occupation. This occupational therapist has had ten years of experience, two



Attractive lamps, baskets, flower boxes, trays and sewing stands are made in the reed and raffia work.

of which were obtained as head reconstruction aide in military hospitals. Under her direction university students from the College of Education conduct the hand work. During the past year the students have given 3,512 hours to our work and the patients have spent about four times as many hours.

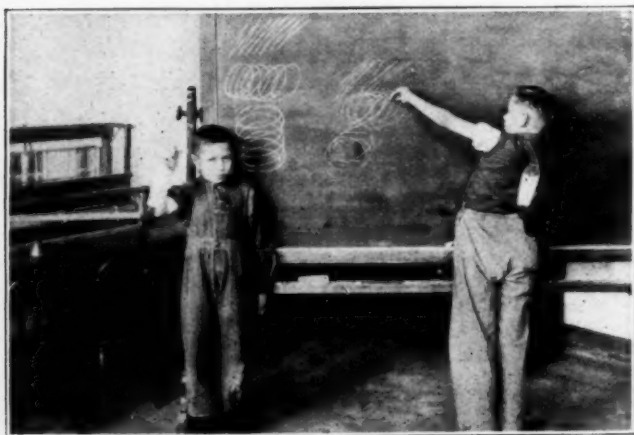
We were especially fortunate in being able to secure the cooperation of the departments which provide the student teachers. Without them we should not be able to carry on the work on nearly so large a scale. The youth and enthusiasm of these teachers contribute an element of joyousness to our work, which, combined with their fidelity to the tasks assigned them, offset to a great extent their lack of experience.

The Therapeutic Cases. During the year ending July 1, 1921, eighty-nine cases of deformity of the upper extremity were treated. In the two years since the work has been organized, 123 cases have been treated. Of these, seventeen have been in the classes both years.

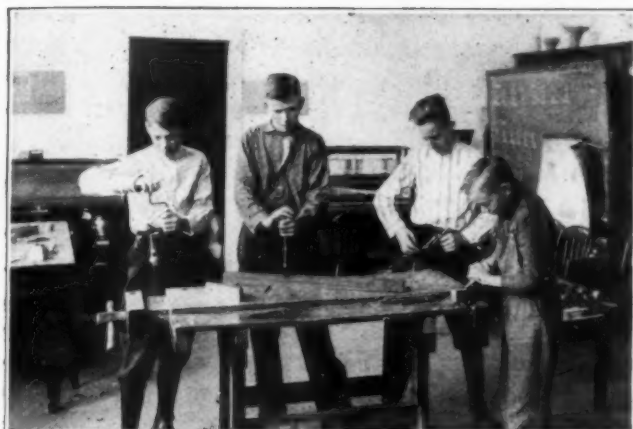
These eighty-nine cases devoted about seven thousand hours to strictly corrective work, and in addition over a third of them entered the general classes in supervised play.

The Corrective Work. As has been noted above, two forms of work are used: muscle training drills, and craft work.

The muscle training drills constitute the connecting link between mechano-therapy and craft work in our plan of treatment. The two drills now regularly in use are the cube and peg drill and the arm raising rhythmic drill. In both, a series of elementary motions is developed and coordinated. In the cube and peg drill the movements secured are the flexion and extension of the fingers, adduction and abduction of the thumb, flexion and extension of the wrist, adduction and abduction of the wrist, flexion and extension of the elbow, and pro-and supinatory movements.



The arm-raising rhythmic drill is performed in time to music and consists of standard blackboard exercises



In the wood working class many things are made, including stools, lamp bases, small furniture, book ends and toys

These movements are timed and the number of motions accomplished per minute is recorded and charted. Increased control is revealed by increased speed.

The second drill is performed in time to music furnished by a Victrola record and consists of standard blackboard exercises. It is used, for instance, after arthrodesis of the shoulder to secure the substitutionary motions required in lifting the arm. Here records of the height reached are charted.

Calisthenics involving routine exercises for the fingers, hands, and arms are used. The same motions are secured in the spontaneous activity of adapted games. In some cases shadow pictures are used. In others jack straws and jack stones, quoits and bean bags, as well as croquet, baseball, and volley ball are utilized to secure the desired end.

The first steps in craft work involve the use of wax, plasticine or clay which lend themselves readily to manipulation, or to simple weaving where complex motions are not required. As soon as possible the patient is set to work upon some project which is within his power to accomplish and which commands his interest by its use and beauty.

The types of hand work provided are outlined below:

- (1) Modeling: Plasticine and permodello, plaques, toys, beads.
- (2) Cement and Plaster Work: Book ends, tea tiles, plaques, and toys.
- (3) Reed Work: Lamps, baskets, flower boxes, trays, sewing stands, lamp and candle shades.
- (4) Cane Work: Sewing stand, stools, and trays.
- (5) Raffia Work: Baskets, pillow-covers, and table-covers.
- (6) Weaving: Doll hammocks, rugs, and paper weaving.
- (7) Wood Carving: Tea tiles, bread boards, book ends, picture frames.

(8) Wood Work: Stools, lamp bases, small furniture, book ends, book racks, garden sticks, coat hangers, and toys.

(9) Tin Work: Candle holders and shades.

(10) Textiles: Simple hand sewing, embroidery, appliqué work, crocheting, knitting, and hooked rugs.

(11) Painting: Candy and sewing boxes, toys, coat hangers, book ends, holiday cards.

(12) Leather Work. Moccasins, purses, scissor cases, tooth-brush holders and card cases.

In addition the children have made their own decorations for Hallowe'en, Christmas, and Memorial Day as well as their own valentines, Easter cards, and May baskets.

The Recreational Work. The recreational classes do the same kinds of craft work as the corrective cases; and the classes in supervised play are open to any child who is able to participate in them.

During the past year, 251 cases have been enrolled in the recreational work. They have been provided with about nine thousand hours of work and play. This does not include time spent in the garden or in reading provided by the library service.

School Work

The school work and the occupational work are scheduled by the principal of the school. All patients who are able to come to the workroom are provided with occupations or supervised play from eight to twelve. In the afternoon these cases attend school for three hours, taking up the work of the first eight grades. Bed patients are provided with occupations or tutors for school work during the afternoon hours. The teaching staff for the grade work consists of four part-time teachers who are assisted by students from the College of Education.

The total teaching force supplied by other departments to our various forms of work amounted during the past year to the services of twelve



Steel room of the orthopedic workshop.

part-time teachers working as many hours a day as these grade teachers work.

The organization of the school work is necessarily modified by the conditions under which it is carried on. Much of the work is individual in character but group work is used in so far as it is possible. We allow the greatest possible flexibility as to hours and working conditions in order to secure the best efforts of each child.

The patients served in muscle education, occupational work, and recreation are largely children. Only an occasional adult is admitted, as space is limited and the teachers are already fully occupied.

Social Service and Follow-Up Work

The social service work is directed by the extension division of the university, which sends out as follow-up worker a woman of experience whose tact and personality are of the greatest value to the institution. The peculiar situation of the hospital as a center for the orthopedic work of the entire state makes it necessary to keep three aims in view in this connection:

(1) To insure the return of the patient to the hospital upon the date set by the staff at the time of discharge. The average stay in the hospital after operation is between three and four weeks. The necessity of evacuating patients at the earliest possible date involves the question of transportation for patient and escort. Although the state bears this expense, which amounts to a considerable figure each month, it is cheaper than to maintain the patient in the hospital. The routine of discharge includes a record of the patient's condition and his needs, and a letter to his parents advising them of his condition and of the time set for his return. By a cross index card system a record is kept of the dates set, and delinquent patients are reported to the social service worker for further action.

(2) To establish sympathy and understanding

between the institution and the homes from which the patients come. The information furnished the medical staff as to the social and moral surroundings, and the economic and sanitary conditions of the home is a useful guide in the discharge of patients. On the other hand, the field worker has been instrumental in interpreting the hospital to the home. There is no question that, in the early stages of the organization, when the work proceeded laboriously and with difficulty in spite of the most general help and the enlightened support of the state university administration, there were many things in which the public had to be indulgent with the growing institution. Especially was this true in regard to deficiencies in the brace work, incomplete reports, and other forms of imperfect clerical work. However, the people of the state have been, in general, extremely fair minded and most appreciative of the services rendered.

(3) To secure cooperation between the hospital on the one hand and the public health nurses and the school nurses on the other hand. In view of the fact that it would be a physical impossibility for one social service worker to visit the ninety-nine counties of the state more than once a year, the institution has to depend very largely upon the cooperation of the school and public health nurses. It is the sentiment of the chief of staff that this phase of the work should be enlarged by instruction given these nurses in the after-care of orthopedic cases.

Summary

(1) The organization of orthopedic work in a center involves establishing many associated branches and is a complicated structure which can be built up only by years of strenuous and consistent work.

(2) Facilities for student and volunteer help enlarge the possibilities of service in such phases of the work as mechano-therapy, muscle education, occupational therapy, supervised play, and strictly educational work.

(3) The control of the patient through a follow-up system is greatly enhanced by complete cooperation between the social worker and the medical staff on the one hand and the social worker and the public health and school nurses on the other.

(4) The work of the Iowa State University orthopedic service is still lacking in provisions for work with adults along such lines as occupational therapy, vocational training, social and recreational life, and an employment bureau through which the handicapped may find work.*



The leather and fitting room of the orthopedic workshop

*A state board for vocational training has recently been organized and is already doing most creditable work.

THE INDIVIDUAL ROOM HOSPITAL—THE HOSPITAL OF THE FUTURE*

BY L. J. FRANK, SUPERINTENDENT, BETH ISRAEL HOSPITAL, NEW YORK CITY

IF AN individual of ordinary intelligence were asked, when he was ill, whether he would prefer to be in a private room in the hospital or in a bed in the ward, he would invariably choose the private room. There must, therefore, be advantages in this private room method of treating the sick, and it is the purpose of my present paper to discuss these advantages.

In the theory underlying the planning of the individual room hospital, one must discuss three essential factors: (a) the room proper, (b) the service, and (c) the nursing.

From a practical point of view the great advantages of a room for every patient might be counterbalanced by the inadequate service arrangements and by the great work thrown upon doctors, nurses, and other hospital employees. To facilitate service and to aid the medical entourage, we have devised the individual utility room, which solves our problems.

Between every two rooms there will be a utility room which will contain all the necessities for service, including water closet, bed pan disposal, wash basin, sink, stove, cold drinking water, etc., etc., and the rooms will have all connections to make certain examinations such as x-ray, electrocardiograph, etc., and certain treatments such as Brand baths for typhoid fever, continuous baths for skin and nervous diseases, etc. We shall discuss the factor of time saving by this utility room later in the paper.

No increase in the nursing staff will be necessary; in fact, if anything, the nursing help will be reduced. As it is, for example, it is requisite to assign twenty-eight nurses to four wards of twenty-four patients each. These wards include many patients who are convalescent and need almost no attention. We plan to remove these convalescent patients to "dormitories" where one nurse at night and one or two nurses during the day will suffice for the ward. This will permit of concentrating the nurses' attention on the sick

The advantages of the single room type of hospital, according to Mr. Frank may be classified as esthetic, therapeutic, hygienic, administrative, and economic.

Esthetically, few will question the advantages of the single room. Therapeutically, there are certain advantages surely, such as the possibility of quiet, a suitable temperature, etc. Hygienically, single rooms will tend to check contagious diseases. The administrative and economic advantages which he feels sure are there, but which might seem more questionable to others, Mr. Frank sets forth in a forceful manner. He feels that aside from questions of humaneness this type of hospital is more economical to construct and to maintain.

patients and will thus reduce the number of nurses in the staff.

If I were asked to classify the advantages, I would do so under the following headings: (1) Esthetic; (2) Therapeutic; (3) Hygienic; (4) Administrative; and (5) Economic.

Where does the patient of means wish to lie? Surely we construct the private pavilions for those that can afford privacy, because we see advantages in permitting a

patient to recuperate in peace and quiet.

We have repeatedly affirmed that most hospitals were not built for the absolute comfort of the patient, and that in many hospitals the comfort and convenience of the attending physician were the only important considerations. Most people dislike to go to a hospital because they dread being huddled into chambers of beds where they lose their identity and become a number, resembling in this regard the convict who in the record is spoken of as number so and so, rather than John Brown, an all-important, suffering, sinning, and sinned against human being. They fear to lie in proximity to a moribund patient or to a patient suffering from a foul disease. As soon as he can at all afford it, the average patient seeks for privacy. He wants quiet and drawn shades. He wants peace, so that his nerves may be rested. The ordinary individual has a sense of modesty, a desire not to impose upon his neighbor if he can help it. He is reluctant to attend to nature's wants in public and thus, sometimes his recovery may be retarded by this natural embarrassment.

In the individual room, the patient, whether he is rich or poor, is treated as an individual, not as one of an aggregate of suffering mortals. The patient will appreciate it very much. He will be able to attend to his calls of nature without having his sense of modesty outraged, nor need he wait for his bed pan because it happens to be visiting hours or meal hours or round hours, etc. I want to stress this point with great emphasis. Comfort, contentment and quicker convalescence

*Received for publication April, 1921.

depend upon these little things. The patient will respond to such thoughtfulness, and the sensitive patient will not only feel much better, but will not be influenced by the unesthetic, disagreeable odors emitted by his neighboring sufferers.

The patient in the hospital is always under nervous strain. He worries when he sees his neighbor taken to the operating room; he worries when he sees him coming back. He is all atingle with excitement when the doctors begin crowding around one patient, when the nurses hurriedly and ominously surround a bed with the white screens. He knows that danger is threatening; he hears the shriek of the patient in agony and then the death rattle. Surely these are not conducive to recovery. In the individual room all these annoyances are obviated.

The tragedies that sometimes enact themselves in a hospital should be, as far as possible, kept away from the other patients. It has happened, in the wards, that a cheerful patient recovering from an operation is about to be discharged when an embolus suddenly snuffs out his life. The impression cannot but be depressing on the ward, but the individual room will preclude such tragic, dramatic episodes. A patient in his delirium or in a state of melancholia attempts to commit suicide. Surely, the effect on a nearby cardiac or hysterical woman is not salutary.

At night the patient has rest, real rest. He is not disturbed by the delirious, noisy patient. He is not awakened by his neighbor asking for water, or by the doctor and nurse attending to the very sick case. Nor will the patient at any time of the day be disturbed by the lights, bells, signals, and other hospital noises.

Therapeutic Advantages

Each patient has his own suitable room temperature. One patient with pneumonia may need the windows wide open, and the steam off. The next patient may need warmth and steam inhalations for his acute bronchitis. One ill man may need sweatings and hot packs for his uremia and his neighbor may need ice packs and cold air for his excessive temperature. One patient may need a stimulant and another a sedative. One cannot please all or treat all properly by one routine procedure.

The patient may need sleep and rest during the day, with quiet and drawn shades, because he is a nervous individual just entering his convalescence. Deprive him of this treatment and he may have a relapse and his recuperation may be long delayed. The next patient is a cheerful young man. He loves visitors and sunshine and he will only improve under cheerful surroundings. Surely both should receive attention according to

their individual requirements. Only the individual room solves this problem.

The patient will feel that he is receiving individual attention in the private room, and in patients who are oversensitive, this psychological factor helps very much in restoring them to health.

Hygienic Advantages

It is well known that single rooms will tend to check contagion of disease. The patient coughing or sneezing will not convey his infectious germs to his neighbor. Each room is, thus, an isolation room.

Suppose the patient, while in the hospital for an operation, develops a contagious disease. The authorities need not transfer this very sick patient to a contagious disease hospital, nor need they worry about the rest of the patients in the ward. Each room is a ward unto itself, and can be washed or fumigated after the discharge of the infectious case, without the necessity of closing up the whole ward under quarantine.

Suppose a patient has a violent hemoptysis. He is not immediately rushed away from the hospital on the suspicion that he is tuberculous. No hurry is necessary. The patient is studied, and if tuberculous, and not cardiac, he is either allowed to remain, if amenable to treatment, or he is transferred in a leisurely and humane way to the proper place for his case.

"The American Hospital Association heartily endorses the progress of the War Department for the control and treatment of venereal disease, and they urge the hospitals of this country to cooperate with this program in every way, and particularly by developing or, when necessary, establishing clinics for the treatment of venereal disease and by opening wards to patients with these diseases who require bed treatment." So reads a resolution of the American Hospital Association. Surely such patients can be treated in the individual room hospital. The individual with a venereal disease requires just as humane treatment as the typhoid patient. It is not right to force a human being who has certain religious scruples to go to a municipal hospital. Syphilis is not a more vile disease than cancer or tuberculosis, and much can be done for venereal disease patients if properly treated.

Administrative Advantages

All patients may see their visitors (with the permission of the physician) every day. This is both a therapeutic advantage and an administrative advantage. Patients usually delight in having visitors, and it thus enhances their recovery. These visitors also take care of the minor wants

of the patient, thus saving the nurses labor.

The noise, the bustle of many visitors on visiting day in the wards has a very exciting effect on most patients. It is known that the expectation of visitors causes the temperature to rise and the pulse to quicken. In the private rooms, the presence of visitors is not so annoying nor does it leave any exciting impression. In the wards, the presence of a visitor at an unusual hour forebodes danger, and has a disquieting effect upon all. The patient who is used to seeing visitors at any hour does not become worried when they come at unusual times. The fact that visitors are allowed at any hour will reduce the population of the hospital at any one time, and in case of panic will not tax the exit facilities as it would if any misfortune should arise under the present system during visiting hours.

We wish to call specific attention to the fact that without an individual utility room, the private room system may not be feasible economically. With the utility room between every two rooms, I think that all such problems are solved. The time and labor of the nurse in responding to and executing a request of the patient is much saved. Without a utility room the nurse has to make the following steps in executing a patient's demand: (1) She goes to the patient and inquires what he wants; (2) Goes to get the article (bed pan, for example); (3) She goes back to the patient with the article; (4) Returns to her desk to wait until patient is through; (5) Goes to patient to get the bed pan; (6) Takes the bed pan to general utility room; (7) Goes back to her desk.

With the utility room near the patient, many of these steps are eliminated and labor and time are saved.

The rooms will be much neater and cleaner. No unnecessary individual articles will be kept in the rooms; they will all be in the individual utility room.

There will be a double system of corridors, so that serving the patient will not interfere with the passersby in the main corridor.

No separate rooms will be necessary for dying cases. This is a very great advantage from the esthetic and administrative points of view. The effect on the rest of the ward when a patient is taken away to these separate rooms is bad. They know that patients usually do not return; and they are nervous for the rest of the day. All human beings fear death, and the sick individual very much more than others. It is surely not desirable to augment this fear, and the horrible effect of the removal of the conscious dying individual to his death chamber need not be dilated upon. Surely it could be avoided.

The hospital will also be saved the necessity of having separate rooms for postoperative cases, for labor cases, etc. The individual room may many times serve as the anesthetic room with marked beneficial effect upon the patient who fears being taken to the operating room.

It has quite frequently happened that a patient in the surgical ward who came for an operation became disheartened when she saw her neighbor being prepared for the operating room, saw her brought back with the vomiting, the wretched feeling and the postoperative pain so universal in all surgical procedures. And not only was she discouraged, but often she refused the necessary operation and was discharged an invalid from the hospital.

Patients will be admitted in the order of their arrival, regardless of sex or disease. Very frequently the hospital clerk has to inform the doctor that he only has beds for males, females, or children, depending upon the state of occupancy of the various wards. A surgical patient seeking admission may be told that "We are sorry, but we have no room for surgical cases. Only beds in the medical wards are vacant now." The patient cannot choose his ailment, nor should the patients be limited to the number of beds assigned to the various medical and surgical services.

The wards will not have to be closed for painting or cleaning. Each room will be cleaned in its turn. In this way the whole hospital can be practically overhauled with very little loss of bed space.

Economic Advantages

What are the economic advantages of the individual room system? Let us first ask in what does a hospital deal? Its main business is to restore sick people to health. Anything that will tend to a quicker return of health is an economic gain. It will be seen from the other advantages pointed out that health will be attained much more promptly in the individual room than in the wards, and thus the average number of patient's days will be reduced.

Some of the reasons adduced by those who oppose the single room plan are: (1) The cost of construction would be enhanced. (2) Hospitals that are constantly under pressure have few empty beds, so the saving of maintaining empty rooms is not a fact. (3) For equal nursing service the cost of nursing will be greater. (4) The increased nursing and domestic personnel will be hard to obtain. (5) Wards from one to four beds each are amply able to meet the needs. (6) Patients not requiring constant attention will complain of lonesomeness.

The objections raised by opponents of the indi-

vidual room hospital are, it seems to me, easily answered.

(1) The cost of construction will not be increased. For, while the partitions may cost more, the height of the ceilings will be less, and thus a great saving will be made. In a ward the number of cubic feet assigned to each patient varies according to window and door exposure. In the individual room system no limitation is placed to the cubage. We must remember that we cannot huddle as many patients into a ward as we were accustomed to, if we are to have conscience and obey the spirit of the hygienic law that patients are to be kept ten feet apart. From this point of view, the partition of the ward into rooms is a great economy, and, if cost of bed construction is considered, many more beds can be had by the individual room system than by the open ward.

Unquestionably the stay of a patient in the hospital will be shortened by the individual room plan, so that the "turnover" of patients will be markedly increased and thus act as a great economic factor. This increase in "turnover" may be between 10 and 20 per cent.

To save the physicians' time, his patients—whether free or part pay or full pay, male or female, adult or child, may be grouped together, so that the time taken for rounds will be shortened.

(2) It is stated by some opponents of the plan that hospitals under pressure never have empty beds. I wish to call attention to the fact that while one ward may be overcrowded, another ward will be slow. This cannot happen in the single room system, for males and females, children, medical or surgical cases, may be placed side by side.

(3) Nursing cost will not be greater. With the utility room in close proximity to every individual room, the nursing cost will not be enhanced, as has been explained above. The fact that visitors are allowed at all hours of the day will cause a great saving in nursing labor, because the visitors will be glad to attend to the minor demands of the patients.

(4) The two-bed room system is certainly not good. One cannot have two individuals whose likes and dislikes are similar and who will sleep, eat, talk, and attend to the calls of nature simultaneously. We do not crowd a patient in his home. Even there we give him privacy and quiet.

For the out of bed patient who seeks company and who needs not to be served at his bedside there will be a "dormitory." These dormitories will be open wards, where patients who can walk to the service rooms will be accommodated. No patient will be kept here who requires service at

his bedside. Thus a patient in this ward, requiring dressing or massage, etc., will go to the place where such treatment will be accorded to him. This ward will be equipped with all the accessory rooms customary for the conventional ward. For the other patients, his relatives and friends will be sufficient company, and not the aches and woes of a sick neighbor.

Dr. Flexner Favors Individual Rooms

If additional arguments are needed, I would state the following: Dr. Simon Flexner, president of the Tenth Congress of American Physicians and Surgeons, in his address¹ at Atlantic City, June 16, 1919, said that "In respiratory infections, diseases in which the inciting organism enters the body by way of the air passages, protection can only be obtained by safeguarding one person from another, that the lesson derived from the severe experience of the recent pneumonia epidemic is to the effect that such patients are not to be assembled into large groups or kept in open wards, but should be kept in separate rooms where they and their attendants may be preserved as far as possible from sputum droplet contamination."

The report on the prevention of influenza by the Committee on Public Health² at the meeting held at the Academy of Medicine on February 20, 1919, states that the etiology of the disease is an x factor, probably a filtrable virus disseminated by droplet infection and indirect infection through contaminated hands, eating utensils, etc.

"Infection can be prevented by guarding against coughing, sneezing, and spitting. The danger zone about the patient is four feet during ordinary and loud speaking, during coughing ten feet. To prevent infection the cubicle system in hospitals is advocated."

Patients Should Be Ten Feet Apart

According to this report, patients in open wards should be at least ten feet apart. This would mean that in the open ward which measures about seventy-one and one-half feet long, where we expect to place twenty-four patients, we should not place more than five patients on each side of the ward or ten patients in all. By placing twenty-four patients and just keeping the patients three feet apart, in accordance with the rule adopted by the New York State Board of Charities, we are keeping within the letter of the law but not within the spirit of the law. Under the separate room system, the patients will be guarded against infection, and greater accommodations will be provided within the same space. In other words, instead of the separate room scheme re-

1. Jour. A. M. A., Sept. 27, 1919.
2. Medical Record, March 29, 1919.

ducing the number of patients and increasing the cost of bed construction, it increases the number of patients and decreases the cost of bed construction, and gives each patient the necessary security against infection.

The *New York Times* in an editorial of January 13, 1919, comments on the Carson C. Peck Hospital, Brooklyn, as follows, giving us this viewpoint of the lay public on this subject: "This new hospital represents a comforting tendency in the modern treatment of the sick, a swinging toward consideration of the personal needs and wishes without sacrificing any of the authority of knowl-

edge and trained judgment. No patient who has lived in hospitals of an only too familiar old-fashioned type can hear of a place in which he can have not only the technical services he may require, but freedom from noise, prompt attendance, hot meals, fresh pure air and sunlight, beauty of view, the pleasure of good color and well designed furnishings in his room, and, what to many will be the last word in comfort, the privacy of a cubicle inclosure if a private room is beyond his means, without feeling that this latest development of the hospital idea justifies its related word, hospitality."

WHAT DOES THE PUBLIC THINK ABOUT YOUR HOSPITAL?

BY HAROLD J. SEYMOUR, TENAFLY, NEW JERSEY

ONE of the commonest disappointments to be met in hospital management is the general apathy with which the public often greets an institution's urgent appeal for funds. The board of trustees, confronted with an operating deficit, or with a need of further capital funds for adding to the physical plant, rightly reasons that the hospital is a necessary public servant, and that the public's own interests demand a prompt and generous response to the hospital's appeal. The board is puzzled to find, however, that the public is only mildly interested, and beyond a few dollars spent at a charity bazaar is perfectly willing to let the hospital get along as best it can.

The real puzzle in this situation is why the board is puzzled. One of the trustees, let us say, is a layman who owns a large department store. His merchandise is good. His service is good; the community actually needs what he has to sell. And yet, he is probably the biggest advertiser in town. Another member of the board, from the hospital staff, is a neurologist, who knows psychology backwards and forwards. He knows the great inertia of the mass mind; what a tremendous stimulus it needs in order to be stirred to action. Every member of the board is a patriotic American, of course, and during the war

"Many hospitals make the mistake of waiting until they need the public's support before inaugurating a publicity program. They find, by doing so, that an extensive period is necessary for telling about the hospital, before anything can be told of the hospital's needs. In time, it is believed that all important hospitals, like all large universities will conduct publicity programs the year round; on the sound theory that institutions which depend on the public for support actually owe it to the public to publish what they are doing. Such an attitude toward publicity will result in prompter and more generous support. It will also tend to present hospitals in general in a different light."

bought Liberty Bonds "until it hurt." What they should all remember, and apply in a small way to the problem of the hospital, is that the government spent millions of dollars in telling them why they should buy those bonds. The simple answer is that the hospital must have publicity before it can have wide support.

The nature of such publicity, and how it should be conducted, are questions interpreted in several ways. One interpretation, that of a large maternity hospital in New York City, is that publicity should be confined to the activities of a financial secretary whose business it is to write appealing letters to persons of means making a formal request for financial support. The chief merit of such a system is that it pays its own way, and is better than nothing at all. Another interpretation, which shall form the basis for the observations which follow, is that hospital publicity should be a campaign of education, in which the public is merely informed concerning some of the many interesting things the hospital is doing.

From Liberty Bonds to hospital funds is not such a far cry, after all. John Price Jones, former assistant director of publicity in the Liberty Loan campaigns for the Second Federal Reserve District, was one of the first to apply funda-

mental publicity principles to hospital requirements. These principles have proved themselves with many important institutions; notably in New York City with the Post-Graduate Hospital, the Broad Street Hospital, and with the fifty-seven non-municipal institutions associated in the United Hospital Fund. Any hospital, regardless of its location, can follow the same procedure with benefit.

First of all, the conservative-minded should abandon the idea that newspapers are interested only in the sensational. They are, it is true, "quack" newspapers just as there are "quack" doctors, but for the great majority of the press, as with the great majority of the medical profession, the chief aim is honest and sincere. The press aims to give a fair diagnosis and an impartial treatment of the news; to tell the public what is going on in the world, and thus to serve as an instrument of education.

From this point of view, the first requirement of hospital publicity should be to tell the public something the public ought to know; to educate the public on matters of public health. It is not enough to make a formal announcement that the hospital needs money. The public must be shown that the hospital deserves it. To do this the hospital must tell its story.

What shall the story be?

He who prepares the publicity must satisfy two laws; one, the law of medical ethics, and the other, the law of supply and demand. He cannot violate the physician's ancient code, which abhors "cures," and he cannot violate the newspaper's code, which abhors that which is distasteful to the lay mind.

A new technique in the application of radium, holding out new hope for the successful treatment of cancer, would make a splendid news story, with an educational value; but the ethics of the code requires that the technique should first be discussed in medical journals. On the other hand, the head of a genito-urinary department once spent a whole morning with me, explaining some of the interesting things the department was doing, and then could not understand why the story would not be of interest to the newspapers.

The things about a hospital which make interesting stories, and which would be perfectly apparent to any good reporter, lie in the dispensary, in certain activities of the medical and surgical services, in certain special departments, and in the details of administration, as follows:

I. The Dispensary.

Perhaps the nearest thing to the public in this department is the social service work. For that reason it is one of the most fertile fields for publicity. The average social service worker has a

vast fund of the very sort of "human interest" stories that a city editor is always looking for.

Other stories, things which the public will be interested in, will be found in the cardiac clinic, the diet clinic, and the clinics on anaphylaxis and mental deficiency. How many people know that a pain in the region of the heart rarely indicates heart troubles? How many parents realize that malnutrition is not necessarily an affliction of the poor? How many sufferers from asthma realize that their spasms may be due to sleeping on a feather pillow? How many people understand the relation between mental deficiency and juvenile delinquency? These are things which the public ought to know, and would like to read about. And in reading, the public will realize that this particular hospital is doing something well worth while.

II. Medical Service.

One of the most interesting questions to any man is the probable length of his life span. The duration of life and the extension of the life span, were close to man's thoughts long before the days of Ponce de Leon and his fruitless search for the fabled fountain. In a hospital, longevity is usually expressed in terms of the degenerative diseases. These are the province of the medical staff, and there is always room in a newspaper for an authoritative discussion of cancer, arterial sclerosis, or the diseases of the kidney.

III. Surgical Service.

Probably of greatest publicity value in this field are traumatic surgery, orthopedic surgery, and surgery of the brain. As a rule, however, it is in this department that successful publicity will be most difficult; the professional code ruling out discussions of rare cases and new technique.

IV. Special Services.

In this field are classified the laboratory, radium therapy, the x-ray, mechano-therapy, unusual diagnostic instruments used in cardiac and neurological work, and the diet kitchens. What is the laboratory doing toward solving the secrets of the suprarenal? What is the hospital doing, or planning to do, with radium? How do the neurologists chart emotional reactions? How much does it cost per day to feed a healthy man on a scientific, well balanced diet?

V. Administration.

At first thought, there would seem to be little material of public interest in the dull routine of hospital administration. But there are dozens of brief and interesting statistical stories to be found on the purchasing agent's cost sheets, on the service records usually tucked away in a table in the annual report, and in the records of ambulance runs. The training school for nurses has its news just as any school has. If it costs more

to run the hospital today than it did last year, say so, and tell why. If unemployment has resulted in an increase in the number of free patients, or if the housing shortage has made it necessary for many persons to come to the hospital for ailments formerly treated at home, let the public know about it, it's *news*.

Tie Up Hospital News and Current Events

These are the apparent sources of publicity material; the things which are essentially of the hospital. But there are also other sources, into which the hospital can project itself merely by keeping in step with current events. This involves "tying up" the hospital's news with the news of the day, offering comment by hospital authorities on pathological crime, epidemics, important medical discoveries or developments elsewhere, or a succession of similar accidents in the city. There are seasonal "tie-ups" also, dealing with sunburn, heat prostration, colds, frostbite, cold exhaustion, and special diets to suit the season. Furthermore, there are opportunities to be gained merely by watching the calendar; by noting precautions against tetanus on the Glorious Fourth, by telling how the hospital observes holidays, and what the social service department does at Thanksgiving. Miscellaneous "tie-ups" are to be numbered only by the publicity man's capacity for originality.

The relative value of different kinds of hospital publicity can be analyzed by the varying effects on the reader. There are two appeals: emotional, and intellectual.

The emotional appeal is the stronger of the two; involving the appeal to the reader's self-interest, and to his sympathy. Nothing has such an immediate reaction as the story which applies most directly to the reader himself, and the more readers to whom the story has a direct application the greater the value of the story. For example, a story about a cure for burns by the x-rays has a certain appeal, but there is a much stronger appeal in a story about sunburns; for the simple reason that more people get burned by the sun than by the x-ray. For the same reason, people are apt to be more interested in life extension than in infant mortality.

Don't Tax Sympathy Too Far

After the appeal to selfish interest, the strongest is that which arouses sympathy. The "human interest" story is always welcome; with the reservation that every cloud must have a silver lining. There must be a smile tucked away somewhere in every good "sob" story.

The intellectual appeal is scientific or institutional; dealing either with news of some advance

in medical science, or with news about what the hospital is doing as an institution.

Just a word about mechanical details:

The best method of distributing publicity material to the press, oddly enough, is not to distribute it at all. The ideal method is to call up the papers, ask for the city editor, and tell him what the story is. If it is good enough, and he has a spare reporter, he will undoubtedly send a man to cover the story. But ideal methods are not always possible. Therefore, if a story is to be written at the hospital, the essential requirements are that it should be typewritten, double-space, should give ample authority for all important statements, and should by all means be brief. If the story is to be sent to more than one paper, it is customary to make a notation at the top of the first page, telling at what time the story can be made public.

Hospital Photographs Usually Poor

Hospital photographs are usually so unsatisfactory that a word about them here may be worth while. Experience has shown that the pictorial possibilities in a hospital, from a publicity point of view, can be adequately summed up in three classes—smiling babies, attractive nurses, and intricate apparatus. The rules to be observed in having pictures taken, if they are to be submitted for publication, are to keep the subject looking cheerful, to have the persons in the picture doing something—not looking at the camera, and to avoid picturing apparatus by itself. Someone should be standing near the apparatus, doing something with it. Following these rules, arbitrary though they seem, will save a hospital many dollars in photographers' fees.

Many hospitals make the mistake of waiting until they need the public's support before inaugurating a publicity program. They find, by doing so, that an extensive period is necessary for telling about the hospital before anything can be told of the hospital's needs. In time, it is believed that all important hospitals, like all large universities, will conduct publicity programs the year round; on the sound theory that institutions which depend on the public for support actually owe it to the public to publish what they are doing.

Such an attitude toward publicity will result in prompter and more generous support. It will also tend to present hospitals in general in a different light. Instead of regarding a hospital symbolically, as a place to go when you get sick, the public will take the preferable attitude that a hospital is a place in which to get well. Any hospital manager can take a lesson from the clergyman who advertised his church as a "Cheerful Church." Publicity can make hospitals "Houses of Health."

THE EDWARD HINES JR. HOSPITAL

BY JOSEPH J. WEBER, MANAGING EDITOR, THE MODERN HOSPITAL, CHICAGO, ILL.

THE construction of what is now the Edward Hines Jr. Hospital, (hitherto popularly known as the Speedway Hospital) was begun by Mr. Edward Hines by direction of officials of the war department when the world war was at its height. Our soldiers had been participating in some of the heaviest fighting, and in the fall of 1918 transports were bringing literally thousands of sick and wounded back to the United States for care and treatment. Hospital beds and yet more hospital beds, was one of the crying needs of the hour. The opportunity to secure by Christmas of 1918 a 2,500 bed hospital at the Speedway, for \$1,000 a bed, was therefore eagerly seized by the army authorities. Work was begun in the early fall, and by Armistice Day one quarter of the hospital had been constructed. Since then various obstacles, which need not be enumerated here, have interfered with the completion of the hospital. Now, however, it is being completed and turned over by the contractors to the United States Public Health Service for equipment and operation.

The hospital, which is located at Broadview, Ill., just beyond Chicago's city line, consists at present of six buildings, constructed of brick with stone trimmings: the hospital proper and five smaller structures—an administration building, a power house, a subsistence building, a combination garage, mortuary and chapel, and the residence of the commanding officer. A recreation building is now under construction. The most remarkable thing about the main building of the hospital is its length, which is 2,040 feet—two fifths of a mile. Probably the next most remarkable feature of the hospital is the fact that it is located at the extreme western side of a 320 acre plot of ground, formerly known as the Speedway—a motor racing track. The shape and location of

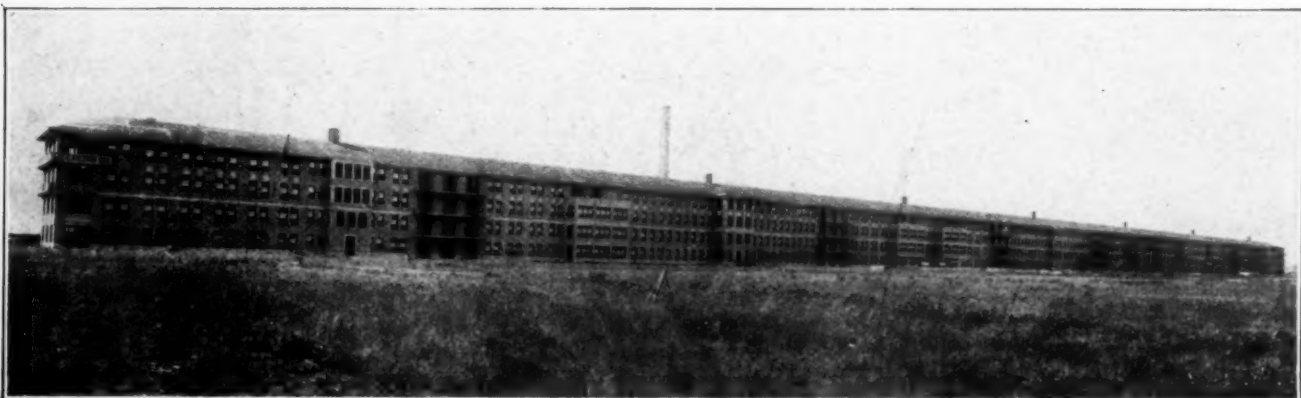
this building were determined by the absurd notion that its construction could be facilitated during the winter months if it were built under the then existing steel-canopied grandstand of the race track.

The building, which runs north and south, is divided for administrative purposes into seven units, or divisions, lettered A, B, C, D, E, F and G, beginning at the southern end. Each of these units may be to a large degree regarded as a hospital in itself, for each unit occupied by patients is in charge of a medical officer who is responsible to the commanding officer of the entire institution for what goes on in his unit.

The building, as originally planned, was to be devoted wholly to the care and treatment of patients. Congress, however, has refused to appropriate funds for the construction of living quarters for the medical staff, the nurses, and the lay help; consequently it has been necessary to set aside and remodel two units and a part of a third unit for this purpose. This practically leaves but four whole units for the care and treatment of patients, i.e., units A, B, C and D. Under the present arrangement unit A, at the extreme southern end of the building is used for cases of tuberculosis, unit B for surgical cases, unit C for medical cases and unit D for psychiatric cases.

Except for the operating suite and a few other rooms, the floors of the main building, corridors, wards and rooms, are concrete throughout. Recently it has been decided to lay strips of battle-ship linoleum down the center corridor and in the solariums at either end of the building.

The walls are painted brown to a height of five feet, and from there up a French gray. The various floors are served by seven passenger and four service elevators, and opposite each of the passenger elevators is a wide concrete stairway.



The Edward Hines Jr. Hospital is two-fifths of a mile long.

The buildings are heated throughout by steam, and ventilated by the natural draft open air type of ventilating system.

The water supply is at present received from the town of Maywood, but two artesian wells, which it is expected will give the hospital an ample supply of good water, are now being driven on the grounds.

Such is the construction of the building that all of the rooms are outside rooms. The spacious windows—in many instances French windows which, with their transoms, extend from the floor to the ceiling, insure abundance of light and air. At night the indirect lighting system makes the hospital very restful.

A modern automatic electric call system, with light, call and release adjustments places the personnel of the hospital within easy reach of every patient.

Although the building is of fireproof construction and contains little material that would burn readily, it is equipped with a modern fire alarm system as well as fire escapes. The institution has three main kitchens, all of which are on the fourth floor. They are spacious, well ventilated and equipped with modern labor-saving devices.

As already indicated, unit A, at the extreme southern end of the building, is devoted to the treatment of tuberculous patients. This section is subdivided into many small rooms, especially adapted for caring for sufferers of this disease. These various rooms and wards are amply provided with baths, showers, and toilet accessories, there being washstands in nearly all of the small rooms or wards. On each floor of this unit are ample solariums which, as the hospital runs north and south, receive the full benefit of the morning and afternoon sun. The picture of one of these solariums is published with this article. Each



One of the larger wards.

floor is provided with a large and well equipped diet kitchen, there also being a general dining room on the fourth floor for the use of ambulatory cases. Each section is provided with elevator service, so that the minimum of exertion is required of patients of this class in going to and from their meals. This unit has its own operating room on the fourth floor. It is also provided with a separate laundry, so that none of the linen goes to the general laundry.

Unit B is devoted entirely to surgical work. On the fourth floor of this unit is located the principal operating suite. It consists of one main and several smaller operating rooms, and the customary accessory rooms, such as anesthesizing room, sterilizing room, nurses' workroom, surgeon's wash-up and locker rooms, and nurses' wash-up and locker rooms. The department has its own connecting corridor, with attractive built-in closets for surgical instruments and nursing accessories, as well as blanket warmers. The floor of the operating rooms is a six inch light gray tile, which is carried up the walls to a height



Individual units of the hospital are admirably equipped. This picture shows the clinical room of the dental suite. The chairs and cabinets are finished in mahogany.



A corner of the main laboratory.

of about five feet. The latter are also painted a light gray enamel, which gives the rooms a pleasant, restful light, a welcome departure from the glaring whiteness of many of the operating rooms constructed during the past two or three decades. Daylight is admitted from the west, north light being out of the question, since the main axis of the building runs north and south. For night work, and accessory lighting on dark days, the operating rooms are equipped with twelve overhead lights with x-ray reflectors and an auxiliary of four gas lamps. This unit also contains a nine room eye, ear, nose and throat suite, fully equipped with every modern device for examination and treatment. There are two recovery wards—one connected with this suite and the other across the corridor. The arrangement and technical equipment of this department will be described in an early issue of *THE MODERN HOSPITAL*. The dental department, located just across from the main operating suite, contains, in addition to the main clinic room, an extracting room, a dental laboratory and the office of the

dental surgeon. The clinic is equipped with seven mahogany-finished Ritter chairs and cabinets with glass trays. Bosworth nitrogen lamps, suspended from the ceiling, are used for operating light. The x-ray department, with its rooms for taking x-ray pictures, fluoroscopic examination, and the development, examination and filing of plates, is admirably arranged, and contains a number of features not commonly found in x-ray departments, such as, for example, the beveled window setting, which gives the operator in the control room a wide range of vision into the x-ray room. The surgical unit also has a well equipped plaster room for its orthopedic cases. All appliances used in this department will be manufactured in the hospital's own orthopedic shop, which is equipped with suitable lathes and other facilities for this work.

Section C is devoted to the care of general medical cases and in construction is practically similar to that described in A. This section is subdivided into many small wards and individual rooms, a distinct advantage in the treatment and care of the various classes of medical cases.

Section D is set aside for the neuropsychiatric cases. All of the windows in this section have screens of the latest approved type which are protective but at the same time do not offend the sensibilities of the patients. This section is amply provided with all forms of hydrotherapeutic and electrotherapeutic apparatus which is now considered so important in treating this class of patients. The rooms devoted to hydrotherapy contain, besides the continuous-flow bath tubs with anti-scalding valves, arm and leg baths, needle and shower baths, perineal douche, seat bath with wave spray, a pack sink and the Barnet type of control table. In this department there is also a tile-lined swimming pool of moderate size. On the first floor of unit F there is a room devoted to occupational therapy for ambulant patients.



The solariums at the southern end of the building are used as open wards for tuberculous patients.

The administration building is two stories high, and is located back of the center of the main building, i. e., directly behind unit D.

On the east side of the lobby is the information desk and telephone switchboard. On either side of this lobby are the admitting department, with a waiting room and several examination rooms, an emergency treatment room located near the ambulance entrance, a reception room, registrar's office, the offices of the director of social service, the compensation office, the post office, and the stationery supply room. The second floor contains the offices of the commanding officers, the executive officer and his assistant, the chiefs of the medical and surgical services, the chief nurse, the chief dietitian and the chief clerk, in addition to the staff conference room, the medical library and the office of the personnel and materiel officers.

The subsistence building is also a two story building, the second story of which is devoted wholly to storerooms of various sizes. The first floor contains, in addition to several storerooms, a large refrigerator, the meat receiving and dispensing rooms, the bakery, which is equipped with gas ovens, and the ice-making plant, which has a capacity of eight tons, and which supplies refrigeration for the subsistence building and ice for the institution as a whole. A railroad siding leads to the unloading platform of this building. In this connection it should be said that a number of small refrigerating plants using sulphur dioxide are located in the garret of the main building and supply the refrigerators of the three main kitchens as well as those of the diet kitchens on the various floors of each unit.

The laundry equipment consists of Troy installation of three forty-two-inch by eighty-four-inch Trojan washers, one forty-two-inch by ninety-



The hydrotherapeutic room is well equipped to serve its purpose.

inch dry room tumbler, three thirty-inch solid curb extractors, one twenty-five-gallon starch cooker and one Big Eight F. W. ironer, electrically operated by remote control board; also four Prosperity garment pressers, ironing boards, etc.

The power house contains eight fire tube high pressure boilers of approximately 190 horsepower, each supplying steam for low pressure gravity return heating system; also supplying high pressure steam for kitchens, sterilizers, blanket warmers, etc.

The fourth building houses the garage, which has a capacity of fourteen cars; the mortuary, with nine compartments; the autopsy room; and a small chapel, having a seating capacity of about fifty.

In front of the main building, a short distance to the east, is the residence of the commanding officer. This is also built of brick and conforms to the general architectural style of the group.

Such is the magnitude of this hospital that it



One of the three main kitchens located on the top floor.

is impossible in an article of this length to do more than sketch its main outlines. In closing, however, it seems appropriate to say that, while the hospital has a number of admirable features, there are a number of others whose appropriateness and wisdom might well be seriously questioned. Take the floors, for example, why are they made of concrete, particularly those in the wards and rooms? Why is not the main laboratory located in a series of small rooms instead of in an extraordinarily large room, and arrangement which makes classification of the various functions of the laboratory next to impossible, and hampers scientific work? Should not provision have been made in the hospital for a central pharmacy? There is no diet kitchen for the preparation of special diets. Why was this omitted? Could there be a more unhappy arrangement than that of locating the chapel opposite the autopsy room, with their doors facing each other? Why does not Congress provide funds for the housing of the doctors, nurses and lay help, instead of allowing one-third of the main building, which was designed specifically for the care and treatment of the sick, to be used for this purpose? These are but a few of the questions that will occur to any visitor who is at all informed on hospital construction and administration. Their number could easily be increased.

SURVEY OF NEW YORK HOSPITALS FURNISHES FUND OF VALUABLE DATA

Valuable statistical material concerning hospital problems will shortly be available for the use of general, special and proprietary hospitals from the findings of the Public Health Committee of the New York Academy of Medicine which is making an intensive and extensive survey of hospitals in New York City. Dr. E. H. Lewinski-Corwin, executive secretary of the committee, reports that the field work of the survey is now drawing to a close and that much of the tabulation is completed.

Data on 181 institutions in the city have been collected. Intensive work has been done on medical organization, the analysis of medical records, social work in connection with the problem of convalescence, the nursing situation, hospital records and reports, cost and several other problems.

On the extensive side, says Dr. Lewinski-Corwin, the committee has gathered complete information on the existing facilities by services, by charges, distribution of patients, seasonal variations and utilization of bed capacity and the methods of admission, charges for laboratory, x-ray, operating and other services for private, semi-private and ward patients.

The study also deals with the income and expenditures of all the hospitals, with the free and paid work and with the valuation of hospital properties, subdivided by grounds, buildings and equipment whenever the latter can be obtained feasibly. Items of maintenance have been subdivided into component parts and percentages figured for each item in every type of institution. Exact information has been obtained as to the various types of

employees and the ratios worked out for each group of hospitals.

Attempts are being made by the committee to learn the size of waiting lists and statistics of rejection whenever feasible so that the adequacy of distribution of hospital facilities and the extent to which the existing facilities meet the demand may be determined.

The problem of convalescence and provision for the chronically ill constitutes another phase of the survey and coupled with it was made a study of medico-, thermo-, electro-, hydro-, and occupational therapy. A survey has also been made of the problem of workmen's compensation in connection with hospitals.

Methods of conducting the hospital survey are the same as those developed by the committee in its dispensary study of last year.

REQUESTS OFFICIAL USE OF AFFILIATION

To aid in the future development of the American Hospital Association, that organization has sent out requests to its institutional members to use the words "Member of the American Hospital Association" on their annual reports and other formal papers. The Association asks that this practice be established pending the development of an official insignia.

Dr. A. R. Warner, executive secretary of the Association, in making this request of hospital members, says:

"This practice will create stability, extend interest in the Association, and make it mean something to each of your communities. All this in turn means greater opportunities to the Association to serve and a stronger incentive to work for the development of the field. The first time there must be explanations to your trustees and to others; then it will be routine and explain itself, but continue to produce results.

"Institutional membership in the Association now means that these hospitals are not only seeking all possible ideas and aid for bettering their local work but are actively interested and contributing to the development of the entire field. They in fact form the front line of those who are pushing progress in hospital work. That is the reason they become members."

HOTEL-HOSPITAL FOR CHICAGO

Construction of a fourteen-story, 500-room hotel-hospital in Chicago, at the estimated cost of \$2,500,000, is being started this month. The hospital, to be called the Franciscan, will be erected at Jackson Boulevard and Wood street in the heart of the city's great medical center. Seventeen medical institutions in that district with their 2,677 beds will be served by the new structure.

The hotel-hospital will accommodate ambulatory patients who need diagnostic facilities of the nearby hospitals, patients awaiting admission to hospitals, discharged convalescents who still need medical observation, relatives of patients at the various institutions nearby, and out of town physicians who are attending special clinics or professional gatherings. The building is expected to relieve congested conditions at hospitals in the city. A small amphitheater will accommodate medical societies, clinics and other professional gatherings.

For 20 years the erection of such a building has been discussed but plans did not take definite shape until late October. The hotel will open about October 1, 1922. Berlin, Swern & Randall of Chicago are the architects.

The noblest motive is the public good.—Virgil.

LABORATORY SERVICE IN HOSPITALS OF LESS THAN ONE HUNDRED BEDS*

BY G. F. STRONG, M.D., ASSISTANT SUPERINTENDENT OF THE VANCOUVER GENERAL HOSPITAL, VANCOUVER, B. C.

IN THE past few years the hospitals of our continent have been most thoroughly impressed with the importance of laboratory work, and recognizing this and the many difficulties connected with carrying out the service, I have been prompted to present this brief paper, designed to set forth in as practical a manner as possible the essential minimum laboratory service which should be found in every hospital caring for the sick. It presupposes cooperation between the large and small hospital laboratories, especially in relation to the training of technicians and the performing of certain complicated technique which cannot be carried out in the smaller laboratory.

The laboratory service probably represents our most efficient aid in proper diagnosis, and includes besides the Clinical Laboratory—the X-Ray, the Electrocardiograph, the Respiration Calorimeter and other such instruments. I shall consider only the Clinical Laboratory and shall outline the requirements of such in a hospital of less than 100 beds. I will try to set forth the fundamental and minimum service which every hospital should give. Larger hospitals should have a much more highly organized laboratory department than that which I am describing.

The object of any laboratory service is, of course, to aid directly in making or confirming a proper diagnosis, thus so guiding the treatment that the patient may be returned to health in the shortest possible time and in the best possible condition to be of use in the community.

There are certain essential requirements that any laboratory must fulfil. Its work must be accurate, the clinicians must be able to depend absolutely on the laboratory reports. It must be so organized and maintained that it can report its findings promptly. The service must be accessible to all. The laboratory depends for its exist-

The cost of equipping and maintaining a laboratory in connection with the small isolated hospital is thought in many cases to be prohibitive. Consequently such institutions are denied that laboratory service which is so valuable an aid to correct diagnosis. Dr. Strong of one of the largest hospitals in Canada has prepared a list of laboratory equipment for the small hospital which allows a wide field of service at a low cost and he believes that the installation of such equipment for ordinary examinations, combined with a system of cooperation between small institutions and large central laboratories in the execution of the complicated tests, will help to solve this great difficulty.

ence on the intelligent use of its facilities by the clinicians. Such use can only come when the clinicians are well acquainted, not only with the laboratory procedures and their constant improvements, but with the technicians who are carrying out these procedures. Close cooperation, therefore, is to the advantage of all.

The laboratory must be equipped to examine urine. The examination must include the deter-

mination of specific gravity and the reaction, the tests for albumin and sugar and the microscopical examination of the sediment. Specific gravity is especially important in certain forms of chronic nephritis in which this factor tends to become fixed. Albumin is most commonly found in the nephritides, also it is especially important as an early indication of renal trouble in pregnancy. It is sometimes necessary to determine the amount of albumin excreted. This can be done with a sample from a 24-hour specimen. Sugar is present in a number of conditions. Its continued presence in the urine is usually diagnostic of diabetes mellitus. In some conditions it is desirable to know the amount of sugar excreted each day and this is easily determined.

The nature of the sediment, as determined by microscopical examination, is very helpful in diagnosing acute infections of the kidneys, ureters, and bladder, and the chronic nephritides. The examination of the sediment for tubercle bacilli is the only positive test for tuberculosis of the kidney. Sediment for examination is best collected by centrifuging a freshly voided specimen. It may be obtained by allowing the urine to stand for some time, but the centrifuge offers a much quicker and more certain means of collecting all the sediment. There are many cheap and efficient centrifuges on the market; some run by water power, others by electricity, and others by hand. Of the other than routine tests, the most important is the test for diacetic acid. This substance is important when it can be taken as a

*Reprint from the proceedings of the British Columbia Hospital Association convention held at Kamloops, B. C., in July, 1921.

sign of acidosis and, in the treatment of diabetes mellitus, it is quite essential that it be tested for daily. Another test that might be demanded in certain cases is the test for bile. Though this is by no means as simple as the previously named test, it may be done in the small laboratory and the results will occasionally justify the effort.

I do not believe that the other more complicated urine tests, such as the one for urea, diastase, total nitrogen, etc., should be attempted. There are very few cases in which these tests are absolutely necessary for a diagnosis, and in such an event the cases had better be sent to the more fully equipped laboratory center.

There are the functional renal tests, however, which must not be overlooked. The phenolsulphonephthalein test is the most important simple test we have to give us an accurate idea of renal function. The technique is extremely simple and the result very valuable. Another functional test that is extremely useful is the Mosenthal test or a modification of it. For the small hospital the simpler technique of the so-called two-hourly test is more apt to be properly carried out and is quite as valuable in its results.

Blood Examination

The first requisite for a blood examination is a technician who can count blood corpuscles with accuracy. The degree of error of such count must not exceed four per cent. Such proficiency can only be attained by practice; for this reason, a non-medical technician who is able and willing to spend a great deal of time at this work is superior to a physician. Next, it is necessary to have a properly standardized hemocytometer and a reliable microscope. The most important test in the majority of cases, is a white and differential count. This is essential in acute surgical conditions, especially those involving the abdomen. The red count and the examination of the red cells in a blood smear to determine any abnormalities of morphology and to detect the presence of any abnormal red cells, is of importance in the anaemias, as is also the estimation of the hemoglobin contents of the blood. This latter determination is done in many ways. The simplest, and perhaps the best method for small laboratories, is the so-called Tallquist method which is also the cheapest means available. For more accurate results, especially in low hemoglobin findings, a more accurate apparatus must be used, such as the Sahli Hemoglobinometer. A complete blood count, consisting of a red and white count, a differential, an examination of the morphology of the red cells and a determination of the hemoglobin, might be well done as a routine on medical cases. Where time for such a complete examina-

tion is not available the following procedure is helpful:—It has been found that for practical purposes, if the hemoglobin is above 75 per cent, and if the case is not one of anaemia of some form, the red blood cells will always be within normal limits. Also it has been found that in non-acute conditions, if the white cell count is within normal limits, a differential is not necessary. Thus, in many cases, a practically complete blood examination may be performed by determining the hemoglobin and the white cell count. A blood count, when not an aid in making a positive diagnosis, is helpful in ruling out certain diseases. The examination of blood smears for parasites is essential, especially in districts where malaria is encountered.

Blood cultures should not be attempted because proper incubating facilities cannot be installed owing to the relatively large expense. By "relative expense" I mean that in considering laboratory equipment we must consider the use that will be required of such equipment. For example: An incubator can be obtained at less cost than a microscope but a microscope is absolutely essential and will be used at least once for every hospital case, whereas an incubator might not be needed except for one case in ten. An incubator, then, is relatively more expensive than a microscope. Serological work, including Wassermann tests, Widal's, etc., should be handled in the large divisional laboratories. Blood chemistry is also somewhat too complex to be attempted without a skilled technician specially trained in this work; besides, the apparatus required is too expensive for the small hospital.

Bacteriological Examinations

For the bacteriological work there must be facilities for the examination, microscopically, of sputum and discharges of various kinds. Further than this the small hospital should not attempt to go, as it involves the expense of proper media and incubators. There should be the necessary stains for examining smears for tubercle bacilli, gonococci and the organisms of Vincent's angina.

Pathological Examinations

The pathological work cannot be done in the small hospital on an adequate scale. The surgical pathology should by no means be neglected on this account. Tissue removed at operation on which a pathological diagnosis is required, can be sent to larger institutions for a report by the pathologist. The tissue so sent, if large and thick, should be cut serially into thin slices so that it will be well hardened. If small, as appendices, etc., it should be left intact. This material should

be sealed in a small bottle containing a preserving and fixing solution and mailed promptly to the central laboratory. The cost of this service should be met by some flat rate based on the bed capacity of the small hospital.

Spinal Fluid Examinations

A laboratory of any size must be able to examine spinal fluid—a cell count and the determination of the globulin are the important tests. The Wassermann on the spinal fluid should be done, with the rest of the serological work, in the central laboratory. The cell count is performed by means of the hemocytometer used in blood counting, with the difference in the degree of dilution used. An increased count always indicates inflammation of some kind. In the acute forms of meningitis there is a high count of mostly polymorphonuclear cells; in the chronic forms, tuberculous and syphilitic, there is usually a lower count and the predominating type of cells is the mononuclear. In syphilis of the brain and cord, as well as in syphilitic meningitis, there is an increased cell count. Globulin also usually means inflammation.

Examination of Stomach Contents

The examination of the stomach contents after a test meal, is frequently very important and should be done more often. The use of this simple test will sometimes obviate the necessity of an x-ray examination, thus saving the patient time and money. This is specially to be remembered in those institutions without an x-ray outfit. The routine examination of stomach contents collected one hour after an Ewald or similar test meal, consists of the determination of the degree of digestion as judged from microscopic appearance; the estimation of the amount of free hydrochloric acid, of the total acidity, of the presence of lactic acid and of occult blood, and the Boas-Oppler bacilli. These tests are quite easily done and do not require technical skill nor elaborate equipment. The results are valuable, not only in gastric disease, but in general disease with some secondary functional or organic gastric disorder.

Examination of Feces

The examination of feces is so simple as to require a mere mention, and yet it is an invaluable diagnostic aid. The examination should be both macroscopic and microscopic in the search for parasites or their ova. Occult blood may be important in chronic intestinal cases. The presence of unusually large amounts of fat points to some disturbance of the external secretion of the pancreas.

This completes the list of laboratory examinations that may properly be made in the smaller

hospital. I have outlined these tests only very briefly, as it has been my intention merely to suggest the possibilities and limitations of the small laboratory rather than discuss laboratory technique. Any small text on laboratory methods will give in detail the above mentioned tests.

The small hospital laboratory becomes, then, in a sense, an outlying branch of the large laboratory. The smaller laboratory, as it grows in volume of work, would be able to take more and more of the necessary procedures unto itself, thus finally becoming an independent unit with a complete staff. The plan of large central laboratories cooperating with the smaller hospitals in the execution of the complicated tests, offers a solution to the problem of furnishing proper means for correct diagnosis in the small isolated hospitals. This whole scheme, of course, applies principally to the small hospital in the small city, town and district, where a larger bed capacity is impossible and where facilities should be afforded the clinicians for good work.

Laboratory Technicians

As to the means for providing such laboratory service, I am convinced that, wherever possible, the non-medical technician should be employed. In view of the fact that in the larger centers it has been found advantageous to use non-medical workers, it seems to me even more imperative that this be done in the small hospitals. The objection that the expense of such a technician will be too great must be met. In the hospitals of fifty beds or more, such a technician can be provided who will also look after the case records and the x-ray department. For the smaller hospitals it will frequently be possible to train a ward nurse to perform these simple tests, while at the same time she might carry on some ward work. The non-medical full-time laboratory worker is, of course, the ideal towards which all hospitals should strive, as it is only when their laboratories are in such hands, directed, naturally, by the physician in charge, that they will achieve the best results.

The interpretation of the results of laboratory tests must rest with a graduate in medicine. The technician fit to carry on this sort of work should be trained in one of the large laboratory centers where it is possible to work under the supervision of the highly paid physicians who have specialized in laboratory technique. Technicians having had such training are competent to properly carry out this laboratory technique. Accuracy and speed can only be attained by long practice under proper supervision, and both accuracy and speed are essential in a laboratory technician. It is not to be expected that graduate physicians can be

employed for such work—the remuneration would be too low and the work too mechanical to justify them in such expenditure of time. Technicians for this work can only be properly trained in the larger hospital laboratories, and in this connection I may add that there has been inaugurated a technician's course at the Vancouver General Hospital that will fit a nurse to do the laboratory techniques as outlined, also the necessary x-ray work, as well as giving her a fundamental knowledge and experience in connection with medical records, particularly as to obtaining, classifying and filing same. A graduate nurse, after such a course, extending over ten months, during which time she spends two months on records, four months on laboratory work and four months on x-ray work, should be the ideal person to handle these three services which are so essential in all hospitals today.

The cost of a laboratory service as I have outlined will, of course, vary with the size of the hospital. The minimum initial cost should not be over \$350.00, which I have itemized in the attached list. The cost of upkeep of the equipment and supplies would be between \$50.00 and \$60.00 per year. The salary of the technician would amount to \$100.00 per month and keep (which would mean \$135.00 per month). This would bring the total cost per month to about \$140.00, which amount could be reduced in proportion to the time so spent, if the technician was working part time on records or other services.

The cost might be met in two ways: Firstly, by making a charge for each laboratory test; and secondly, by collecting a flat rate of so much from each patient per day. The latter of these is, I believe, preferable. The former tends to lay a heavy burden on the few that need a great deal of laboratory work, while the second plan divides the burden so that it is really not felt by anyone, yet it is no injustice because all patients will benefit by the laboratory service in the hospital. For example: In a hospital averaging fifty cases per day, there are fifteen hundred treatment days each month; a flat rate of 10c per day will yield \$150.00 per month, or more than enough to provide such laboratory service. In those smaller hospitals not maintaining a full-time technician, the cost would be proportionally less.

This, therefore, sets forth, briefly, the fundamental and essential minimum laboratory service which should be found in every hospital desiring to do competent work and to take good care of their patients. From such a basis can be developed a much larger and more highly organized laboratory system as the institution grows in size, till finally, the various departments such as pathology, bacteriology, serology, clinical micro-

scopy, blood chemistry, etc., are each organized, having a competent director and staff and giving an efficient maximum service to all hospitals.

LIST OF EQUIPMENT FOR LABORATORY FOR HOSPITALS OF 100 BEDS OR LESS

- 1 gross test tubes, 5 x 3/4, without lip.
- 1 gross test tubes, 8 x 1, for urines.
- Tincture bottles, x x glass ware, ground glass, stoppered, 12—4-oz.
- Tincture bottles, x x glass ware, ground glass, stoppered, 12—6-oz.
- Flasks, Erlenmeyer, 4 100 c.c.
- Flasks, Erlenmeyer, 4 250 c.c.
- Flasks, Erlenmeyer, 4 500 c.c.
- Flasks, Erlenmeyer, 2 1000 c.c.
- 3 Evaporating dishes, diameter 3 in.
- 2 lbs. assorted glass rods.
- 2 lbs. assorted glass tubing.
- 2 Burettes, Mohr Shellbeck, capacity 50 c.c. Grad. 1/10 with pinchock.
- Pipettes, grad. 1/10 c.c. to tip—6 1 c.c.
- Pipettes, grad. 1/10 c.c. to tip—4 5 c.c.
- Pipettes, grad. 1/10 c.c. to tip—4 10 c.c.
- Pipettes, volumetric—3 5 c.c.
- Pipettes, volumetric—3 10 c.c.
- Pipettes, volumetric—2 20 c.c.
- Pipettes, volumetric—2 25 c.c.
- Pipettes, volumetric—2 50 c.c.
- Cylinders, measuring—2 10 c.c.
- Cylinders, measuring—2 50 c.c.
- Cylinders, measuring—2 100 c.c.
- Cylinders, measuring—2 500 c.c.
- 6 T. K. Dropping bottles, capacity 60 c.c.
- 2 gross microscopic slides.
- 2 oz. coverlips, sq. 24 m.m.
- 2 Well slides.
- 2 Buntzen burners (or equivalent, depending on gas supply).
- 2 Iron tripods, 3 inches in diameter.
- 4 Pieces wire gauze with asbestos, 4 inches sq.
- 1 Centrifuge.
- 1 Hemacytometer.
- 1 Hemoglobinometer, Sahli.
- 1 Hemoglobinometer, Tallquist.
- 2 Easbach Albuminometers.
- 2 Urinometers with cylinders.
- 1 Microscope, B. & L., B.B.H., or equivalent.
- 2 Casseroles, capacity 150 c.c.
- 2 Forceps, dissecting, with fine points.
- 2 Forceps, dissecting, medium heavy, straight points, 115 m.m. long.
- 2 Forceps, coverlip.
- 4 Pencils for writing on glass (Blaisdell).
- 1 Colorimeter (Dunning).
- 1 Platinum loop.

NOTE:—This includes equipment only; supplies are not included.

ACADEMIC PROCESSION AT DEDICATION OF PEKING UNION MEDICAL COLLEGE



Many prominent physicians and surgeons were present in late September at the formal opening of the college which was erected and will be maintained by the Rockefeller Foundation. From left to right behind the marshal, who carries the baton, are: Dr. George de Schweinitz, professor of ophthalmology, University of Pennsylvania; Dr. Florence Sabin, professor of histology, Johns Hopkins University; Dr. S. S. Goldwater, director of Mt. Sinai Hospital, New York City; Mr. James L. Barton, secretary of the American Board of Foreign Missions; and Prof. T. Tuffier, surgeon at the Hospital de late Pitié, Paris.

THE HUMAN ELEMENT AS A FACTOR IN THE HOSPITAL LAUNDRY*

BY WALTER TRIMBLE, CHICAGO, ILL.

IN PREVIOUS articles much has been said about the machinery and the methods that are used in the hospital laundry, but there has not been much reference to the human element—the people who use the machinery and carry out the methods. The personnel of the working force should be given careful thought, however, for more depends on it than on anything else.

The manager of the laundry department is a part of its working force, although in a large institution he will not work with his hands. Without a suitable manager and suitable workers, the best equipped laundry plant that can be installed will not produce satisfactory results. I have read much about "machinery that seems to be able to think," but I never have seen any of it in a laundry or elsewhere. If there is any machinery in your laundry department "that seems to be able to think," it is the kind that walks around on two legs—and lots of these two-legged machines that I have seen working in laundries do not even "seem" to have reasoning faculties. Nevertheless, alleged managers employ such people, pay them as much as it would cost to get workers who can think, and expect such dullards to be able to operate complex machinery and carry out difficult methods.

The nearer a machine approaches to "thinking" ability, the more complex it necessarily becomes; therefore, the more brains it takes to operate it. In other words, labor-saving machinery saves labor, but it does not remove the necessity of the operatives' having brains; conversely, it increases the amount of intelligence that they must have. If any person tells you that a boy or girl can operate a complex machine, be sure to discount that statement, for behind the boy or girl, even if one can operate it, there must be an expert mechanic, whose duty it is to watch

The personal element in the hospital laundry is the most important element of all. Equip your department with the best and latest machinery but if you ignore its personnel you cannot hope for satisfactory results. In laundry workers you should first demand a reasonable amount of intelligence. Then you can start to build "morale," that greatest requisite to the production of satisfactory work. Discipline then follows morale, not morale discipline as is so often mistakenly believed. If you get harmony of relationships, gain the confidence of the employees, give them something to work and hope for, and place them in good working conditions you will have nothing to fear.

over machinery of this class. Whenever there is employed an operative without skill and intelligence there must also be a person employed to supply the missing attributes. It is an axiom that as the skill of the workers diminishes the expense of supervision increases.

Thus we see that one should have operatives who have at least a reasonable amount of intelligence. If one has this kind of a working force

he will be able to get morale, the one great requisite to production of work which is both satisfactory in volume and quality. If one can maintain a good morale among the workers in his laundry department, his production problem should be a comparatively easy one, for in that event there is nothing to do but to follow standard practices.

Morale, according to Webster, means "condition, as affected by, or dependent upon, such mental factors as zeal, spirit, hope, confidence, etc.; a mental state." To secure morale one must, we see, have zealous and spirited human elements; then one must give them something to hope for, and must have their confidence. This, it is true, is a condition that is not easily brought about, but it is a state that is worth striving for.

Morale is often confused with discipline, which Webster defines as "training to act in accordance with established rules; accustoming to systematic and regular action; submissiveness to order and control; habit of obedience." Many men waste a great deal of time in trying to develop discipline first and morale afterward, which, as a little applied logic will show, is putting the cart before the horse.

Most of the workers in the laundry department are women, and as the keeping up of morale means the keeping of the women in a good mental state, the matter is one for mere men to ponder. The workers, we see, must be zealous, spirited, hopeful, and have confidence, if the collective morale of the operative force is to be high. How

*This is the thirteenth of a series of articles by Mr. Trimble on the hospital laundry appearing in THE MODERN HOSPITAL.

is one to be able to bring about this much-desired state of affairs?

Must Eliminate the Unfit

Going to the very root of things, one should begin with the employment of the operatives. If one has on his pay roll some unfit human elements, he must replace them. This may seem a cruel way to put it, but it is no more cruel than surgery, and really it is business surgery. The law of the survival of the fittest is cruel, but it is a law of nature, you must eliminate the unfit.

The first factor to be considered in the employment of a person to work in a hospital's laundry department is the physical fitness of the applicant, for no one can perform a task to which he or she is not physically adapted. Some tasks require a strong person and others do not. Do not try to fit square pegs in round holes and vice versa. The next consideration is the mentality of the applicant, or perhaps I should say the mental attitude. Select persons who have a cheerful disposition and who are willing to obey, rather than persons of strong mentality, for your rank and file. You want brains, of course, but you do not want people, especially women, who are too "strong-minded." The executives, of course, should be well-educated persons who are both cheerful and diplomatic.

Do You Pick Your Employees?

Your laundry department, if it is an average one, has a working force that is made up of a heterogeneous collection of men and women, most of whom were put to work merely because they happened along and applied for a position at a time when a worker was wanted, not because they were particularly fitted to their tasks. In other words, the workers picked you out to be their employer, instead of your picking them out to be your employees. If this is the case, you are facing a condition, and not a theory—and you want to bring the morale and discipline up to a reasonable standard.

Can this be done? It has been done, and this would indicate that it can be done again. Experience has shown that it costs but little to do it, and it brings a big return in the shape of lower cost of production and more satisfactory product. Perhaps you will not have to make any changes in the personnel of your working force, but it is probable that you will have to get rid of some unteachable persons and a disturbing element or two. First of all, get harmony. Then get the confidence of all and make all to feel that they will get a square deal.

The workers must have something to hope for, and here may be a stumbling block, for you may

not have much to offer. But there is always something that the hospital management can offer to its laundry workers as a ray of hope, such as better pay for more and better work, with promotion for those who become fitted for advancement. Some workers never will deserve to advance, it is true, but the capable ones should always be able to hope for advancement.

Good Working Conditions Necessary

It should always be remembered that bad working conditions will make it almost impossible to build up a competent, loyal working force, for intelligent people seek employment where the environment is good. It should hardly be necessary to tell the manager of a hospital that his laundry department should be clean, well lighted, have plenty of ventilation, both forced and natural, and have suitable dressing rooms and toilet facilities, so I will not dwell on that subject. Welfare work, if done in the right manner and with the right spirit, is a great help, but if it is done wrong it is a great hindrance. This interesting and important subject will be left open for future discussion.

RED CROSS WORK IN NAVAL HOSPITALS

The work of the American Red Cross in keeping up the morale of the men in Navy hospitals has been summed up by Lieutenant Commander Joel T. Boone, of the Medical Corps of the Navy. He declares that home service as carried on by the Red Cross has been of incalculable value to the hospitals, and although it would be almost impossible to outline exactly the divisions of the work, yet it can be generally characterized under the following heads: Persuading men in the Navy to communicate with their families and the families to communicate with the men. Rendering assistance, upon request, in handling the business difficulties of the men or members of their families. Providing information regarding the Government's program for the welfare of the men, such as allotments, allowances, insurance, vocational training, etc., and assisting in handling difficulties in which the men are involved. Friendly visits to the men when sick or disabled, and keeping their families advised of their progress when advisable, and when approved by the commanding officer. Investigations of home conditions, at the request of naval officers, for confidential information needed in considering questions of medical care and treatment, as well as furlough or discharge. Locating families of men in the service or locating men for inquiring families. Arranging friendly visits to families on request of men in the service.

To carry on these activities, the Red Cross has representatives stationed at the larger hospitals, at some there is even quite a staff of workers. A great deal of what these splendid women are doing is as hard to define as morale itself.

The board of trustees of the Toledo Hospital, Toledo, Ohio, has sent Superintendent P. W. Behrens and Mrs. Behrens on a European tour. They will visit hospitals of note while abroad and observe methods of construction and administration.

THE STANDARDIZATION PROGRAM FROM A SUPERINTENDENT'S STANDPOINT*

BY WAYNMAN CRANE LYON, SUPERINTENDENT, SPRINGFIELD HOSPITAL, SPRINGFIELD, MASS.

IN CONSIDERING the standardization program from the superintendent's standpoint, we will divide the minimum requirements into three general divisions: First, accurate and complete case records; second, adequate clinical laboratory facilities; third, organization of the physicians and surgeons who are privileged to treat patients in the hospital into a staff or group, including membership, rules and staff or group meetings. I believe that we are all familiar with the reasons why the standardization program was undertaken, and also the importance as well as the necessity of all hospitals meeting the minimum requirements. The next question is, "Has experience shown so far that the program has produced any beneficial results where it has been adopted?" From the superintendent's standpoint I would say unqualifiedly "Yes."

Benefits Patient for Whom Hospital Exists

In considering the practical working of any program in connection with hospitals, we must never lose sight of the fact that the hospital exists primarily for the care and treatment of the patient, and in judging results, we must ask the question, "Has this program benefited the patient either directly or indirectly?" The patient places absolute confidence in the hospital together with the physician or surgeon under whose care he is, and therefore believes, and has a right to believe, that everything which is humanly possible, will be done for him by the hospital through means of an efficient organization of trained workers and by the aid of all necessary facilities and equipment for the proper diagnosis and treatment of his case. Experience thus far has shown us that this is exactly what the minimum requirements of the standardization program, when carried out, guarantee to the individual patient.

In the first place, accurate and complete case records are absolutely essential and invaluable for two reasons: First, the necessity of having the information contained therein, available, and an accurate record kept of the patient's condition and treatment from day to day, while in the hospital, for use of the physician or surgeon in charge of the case, in order that the proper treatment may be given him; second, to have this accurate and complete record instantly available, at

any future date, for the information and guidance of any physician treating this patient for some new condition or a recurrence of the old trouble.

Obligation to Patient Calls for Records

No one realizes better than the superintendent, the innumerable occasions when information of this kind is called for, frequently a number of years after the patient has left the hospital. It is unfair to the patient, as well as most embarrassing to the superintendent, if he is able to produce only the very meager and limited information that many hospital records of ten or even five years ago contained. However, the adoption of the standardization program has entirely eliminated this unjust and unfortunate condition, and now the superintendent of any hospital which has met the minimum requirements, can produce at any time, when called for, an accurate and comprehensive history of every patient who has been treated in the hospital.

As time goes on, requests from other hospitals as well as individual doctors for the records of patients, will become more numerous. The fact that all hospitals now meeting the minimum requirements have a more or less uniform set of records, which contain all of the essential information necessary, will be of inestimable value in the future. At the present time, the Springfield Hospital is successfully using trained historians for the securing of all histories in order to have the information contained in them as uniform and complete as possible. These historians, who are graduate nurses, in taking the patient's history, are guided by an outline of general questions to be asked, covering all the essential points. This outline, of course, is flexible, and after receiving answers to the first few leading questions, the historian is enabled to decide which one of the several groups of detailed questions is the proper one to follow, in order to secure the necessary and desired information from the patient. This detailed and uniform history in all similar cases, is particularly valuable to the staff or individual member, when studying a series of cases of the same disease.

Records Sometimes Needed in Court

Accurate and complete case records are of the utmost importance in many other ways, which can only be fully appreciated from the superin-

*Paper read at the hospital section of the American College of Surgeons meeting held at Springfield, Mass., May 13, 1921.

tendent's standpoint, one of which is the absolute necessity of having them available when called upon to produce such records for use in court. It is certainly a decided reflection not only upon the superintendent, but the hospital as well, if an accurate and complete record cannot be produced. In these cases the record is no longer considered as confidential, but it is read in the court room, and the public has an opportunity to judge for itself, whether or not the hospital is meeting its obligation to the patient in this particular. The opportunity for criticisms of this kind is entirely eliminated by the adoption of the standardization program. Any hospital which has met the minimum requirements will certainly have cause to feel proud of its records, when it is compelled to make such records public. They will reflect credit on the organization and develop favorable public opinion toward the hospital. No hospital can exist today without the good will and support of the public in the community in which it is situated.

Having spent effort, time, as well as money, in perfecting an accurate and complete record system, it is of the utmost importance that infinite care be taken of these records, and that they be permanently filed so as to be instantly available. Since these records may be at any time of the greatest value and service to a patient or his relatives, the hospital is certainly under the greatest obligation to take every precaution against any record being lost or destroyed.

In considering the question of adequate clinical laboratory facilities from the superintendent's standpoint, it is a fact that the public has the right to expect and demand that all necessary facilities, as well as equipment be provided by the hospital for the proper examination and treatment of patients. The public, during the past few years, has been educated to realize the value, as well as the necessity of adequate laboratory and x-ray facilities to assist in diagnosis. Any institution is assuming a grave responsibility when willing to continue admitting and treating patients, where these facilities are not available.

Organization of Physicians Most Important

By far the most important of the three above mentioned divisions of the minimum requirements, from the superintendent's point of view, is the organization of the physicians and surgeons who are privileged to treat patients in the hospital. This group organization and the adoption of definite rules governing it, together with the monthly group meetings, has done more than any other one thing in establishing a spirit of co-operation throughout the entire hospital organization. This is, of course, of the utmost impor-

tance and assistance to the superintendent. The adoption of rules governing the group organization has eliminated all incompetent physicians and surgeons, as well as those who are unworthy in character and in matters of professional ethics, and this has automatically solved many of the most perplexing and delicate problems of the superintendent. Should it become necessary to deny a doctor the privileges of the hospital for one of the above reasons, it can no longer be construed as a personal matter between such doctor and the superintendent, but it at once becomes an issue between the hospital as an organization, representing the rights of the patient, and the doctor.

By far the most valuable phase of the group organization, is the monthly group meeting. This is attended by all of the doctors who have treated patients in the hospital during the preceding month. In the case of the Springfield Hospital, the first thing taken up at these group meetings is the presentation of any interesting pathological material collected during the month, with such remarks as the pathologist deems helpful. Or it may be a ten or fifteen minute paper read by one of the doctors on some particular subject of interest to the entire group, this subject having been announced at the previous meeting in order that all may enter intelligently into the discussion.

Casualty Report Read and Discussed

Then comes the reading of the registrar's casualty report, and its discussion by physicians and surgeons responsible for the case or cases in question. The details, as shown by the case histories and testimony of those concerned, are carefully considered by the group, in order that it may determine as far as possible whether the fault lay with the doctor, the patient, the disease, the hospital organization or equipment. This casualty report, and by casualties we mean deaths, infections or complications, becomes a part of the hospital record, and includes the following information:

- (a) Serial case number of patient.
- (b) Name of physician or surgeon under whose service the casualty occurred.
- (c) Percentage of casualties to the number of cases treated that month by physician or surgeon concerned.
- (d) Nature of casualty, i.e., death, infection or complication, etc.
- (e) Diagnosis, pre- and post-operative.
- (f) Nature of operation, if any.

In other words, this report is an absolute record of the work done and accomplished by the hospital during the preceding month, and at the end of the year, a summary is made covering the work

of the preceding twelve months, and becomes part of the permanent hospital records. The results of the work done by the hospital, as shown in this report, should be the basis of deciding whether or not the hospital is justified in assuming the responsibility of treating patients and of looking to the public for support. By this method of group meetings, the superintendent knows at once if casualties are occurring which it is in any way possible to prevent, and furthermore, knows where the responsibility rests and how the trouble may be corrected.

Considering the standardization program in its entirety, one of the most important features, is the fact that the hospital, having met the minimum requirements, is in a position to go before the public when in need of funds, with the statement that it is on the approved list of hospitals, which have been investigated and classified under the standardization program of the American College of Surgeons, and is therefore worthy of the confidence and support of the community, inasmuch as it is meeting its obligations to its patients.

However, it is not sufficient for hospitals to only meet the minimum requirements in a literal sense, because compelled to, but they must enter into the spirit behind the program, if they would derive the full benefit from it.

Accurate and complete case records in themselves mean but little, if they are not conscientiously written and intelligently studied. Thousands of dollars may be spent in equipping clinical laboratories, but it is money thrown away if the facilities thus provided are not taken advantage of and intelligently used in treating cases. The staff may be organized, innumerable rules and regulations adopted, monthly, weekly or even daily meetings held, but they will be productive of no good results unless each individual member realizing his responsibility to his patients, lives up to the spirit of such rules and regulations, and conscientiously attends these meetings in a co-operative spirit.

Therefore, the adoption of the standardization program will produce beneficial results in direct ratio to the conscientious effort expended and the spirit of cooperation with which it is entered into, by the entire hospital organization.

LAURA FRANKLIN FREE HOSPITAL TO BE PART OF FIFTH AVENUE INSTITUTION

The Laura Franklin Free Hospital for Children on East 111th Street, New York City, will become a part of the new Fifth Avenue Hospital on January 1. It will be concentrated on one floor and in its new quarters will be able to take care of twice as many babies as before and in a way not possible in the old quarters. Instead of the

little back yard for a playground the children will have three special playrooms, one indoors fitted up with all kinds of toys and games, one outdoors, and a third a loggia playroom where the children will have the benefit of sun, light and air all the year round.

The Laura Franklin Hospital was founded in 1885 by Mr. and Mrs. Franklin Delano in memory of their niece, Laura Franklin Delano, and it has been entirely supported by this family ever since.

CELEBRATE 100 YEARS OF SERVICE

In celebration of a full century's service in the hospital field, the Massachusetts General Hospital in Boston on October 18 held formal exercises. The observance was a dual celebration of the admission of the first patient to the hospital in the autumn of 1821, and of the seventy-fifth anniversary of the discovery of the surgical use of ether, credited to that institution.

The Massachusetts General Hospital has had a remarkable history and lays claim to the following advances in medical science:

The demonstration of surgical anesthesia on October 16, 1846, by Dr. William T. G. Morton. The patient was Gilbert Allen and the surgeon Dr. John C. Warren. Dr. Morton was last year admitted to the Hall of Fame for this discovery, the only physician ever so honored. From his demonstration the knowledge of surgical anesthesia spread throughout the world.

The demonstration of appendicitis by Dr. Reginald H. Fitz.

The work on puerperal fever by Dr. Oliver Wendell Holmes.

Dr. Richard C. Cabot's demonstration of the value of social service in hospitals.

The demonstration by Dr. E. A. Codman of the value of surgical audit and the follow-up of patients.


On September 1, 1821, was admitted the first patient to the general hospital, it being chartered in 1811 but delayed in opening by the War of 1812 and the subsequent financial depression. McLean Hospital, a branch of the Massachusetts General, admitted its first patient in 1818 as the trustees were able to start the branch for the insane earlier because the buildings and estate of a Somerville citizen could be used.

The anniversary celebration took the form of demonstrations and clinics for the hospital alumni and visiting physicians in the morning and formal exercises in the afternoon.

Presentation to the hospital of a tablet honoring alumni of the hospital who lost their lives in the World War was made in Treadwell library at impressive exercises during the day. The presentation address was made by Dr. Samuel J. Mixter, president of the alumni association. George Wigglesworth, chairman of the hospital board of trustees, accepted the tablet in behalf of the hospital.

Following a luncheon for alumni, formal exercises of the day were held before a large audience in the assembly hall of the Moseley Memorial Building. Dr. Henry P. Walcott presided and addresses were made by Dr. Frederick C. Shattuck for medicine, Dr. Harvey Cushing for surgery, Dr. C. Macfie Campbell for psychiatry, and Maj. Gen. Merritte W. Ireland for the modern development of a civil hospital as an asset to the country in time of war.

In the evening the House Pupils' Alumni Association dined at the Harvard club where speakers were: Maj. Gen. Ireland, surgeon general of the army, and Bishop William Lawrence of the Episcopal Diocese of Massachusetts. Dr. Mixter presided; 100 alumni were present.



The
MODERN HOSPITAL

EDITORIAL AND PUBLICATION OFFICE
22-24 East Ontario Street, Chicago

EDITORS

Henry M. Hurd Fidelity Building, Baltimore
 Frederic A. Washburn . Mass. General Hospital, Boston
 Winford H. Smith . Johns Hopkins Hospital, Baltimore
 S. S. Goldwater . . . Mount Sinai Hospital, New York
 W. L. Babcock Grace Hospital, Detroit
 H. E. Webster . . . Royal Victoria Hospital, Montreal
 R. G. Brodrick Alameda County Hospital, San Leandro, Cal.
 M. T. MacEachern . . . Vancouver General Hospital, Vancouver, B. C.

MANAGING EDITOR
Joseph J. Weber . 22-24 East Ontario Street, Chicago

SUBSCRIPTION

Domestic postage, \$3.00. Canada, \$3.50. Foreign, \$4.00.
 Single copies, 35 cents. Annual Review Number, 50 cents.
 Domestic rates include United States, Cuba, Mexico, Porto Rico, Canal Zone, Hawaii and Philippines.

THE DISTRIBUTION OF HOSPITAL FACILITIES FOR WAR VETERANS

ON SEPTEMBER 21 Senator Stanley of Kentucky introduced senate bill No. 2458, providing for a \$5,000,000 hospital for veterans suffering from nervous or mental diseases. The bill contains a provision which suggests that the proposed hospital be located in the District of Columbia. This site, however, is not mandatory. Immediately after the bill was introduced, an agitation was started to have the hospital, if the bill passed, located in the District of Columbia, and the director of the Veterans' Bureau issued a public statement in which he favored the location of the hospital in the city of Washington or near the national capital.

THE MODERN HOSPITAL and others who are familiar with the country's need of hospitals for mental and nervous cases among ex-service men, are convinced that it would be a serious mistake to build a 1,000 bed hospital for these patients at this point. Washington already has 1,050 beds for neuro-psychiatric patients, at the Walter Reed and St. Elizabeth Hospitals, a number more than enough to meet the needs of the ex-service men in a wide area, as well as the special needs of such a city as Washington, to which patients from the army, the navy and the civilian federal service are constantly being referred for accom-

modations. Moreover, at Perryville and Philadelphia, both within 150 miles of Washington, there are located two of the six neuro-psychiatric hospitals of the United States Public Health Service. They draw from a still wider area.

If the proposed hospital is located at Washington the principle which actuated the White committee in distributing hospitals of not more than 500 beds about the country so as to give a fairly convenient service to the larger population groups in proportion to the known incidence and the expected incidence of neuro-psychiatric diseases among the veterans, will go by the board. Is it the part of wisdom thus to ignore not only the fundamental advantages and medical benefits which will accrue to patients by being located near their families, but also the reasonable and natural human wishes of the families and friends of the patients that they be treated in nearby hospitals?

What of the need of the far west, the northwest and the south? Shall the patients of these regions be transported at great expense to Washington, and thus be separated as far as possible from their friends? Indeed, the complete lack of adequate facilities anywhere on the west coast made it necessary on August 26 of last year to transfer a violently insane discharged soldier from Letterman General Hospital, located at San Francisco, to St. Elizabeth Hospital at Washington, D. C.

Many of the patients who are beneficiaries of the Veterans' Bureau are suffering from temporary, curable forms of neuro-psychiatric diseases, and hospitals should be located near the bulk of the men in order to tempt them to undergo early

The very great victory on behalf of disarmament and peace achieved by the nations of the world should be an inspiration to the members of the American Hospital Association, giving us courage to meet our common problems, stimulating our endeavor to elevate the standard of care for the sick and injured, remembering at this season, and throughout the year, that he serves God best, who serves his fellowmen.



President, American Hospital Association.

care and treatment. Experience has shown that beneficiaries are unwilling to go to distant institutions, where friendly supervision and contact are impossible.

The location of the proposed hospital at Washington will only increase the disproportion between the facilities which have been provided in the East and those which are so badly needed in the South, the Southwest and the North. So serious a mistake should not be countenanced.

EMPLOYING A SPECIALIST FOR HOSPITAL FINANCIAL CAMPAIGNS

NOT infrequently hospitals in need of capital for the construction of new buildings and, less often, for maintenance, turn to financial campaign specialists to assist them in raising funds. This is especially true in communities which have not as yet banded their private civic and philanthropic agencies into a financial federation, or whose activities are too few to make such a federation practicable.

It is not our purpose at this time to discuss the merits or demerits of the campaign method of raising money, but various inquiries from our readers prompt us to comment briefly on the question of employing campaign specialists. Where local leadership for financial campaign work has not been available, honorable, competent campaign specialists have assisted various hospitals in organizing campaigns of this character, and have often done so in a way that has won many friends for the institution. But the campaign method is not without its dangerous elements. The personality and capability of the campaign director may not bear investigation; his methods may not stand critical analysis; the purpose for which the money is to be raised may not be justified; or the campaign itself may not be acceptable to recognized leaders of the community. These dangerous elements may be guarded against if hospital authorities will take certain precautions.

No campaign should be entered upon until a competent, disinterested person or organization has first determined by a local survey of the community's needs that the proposed hospital or addition to a hospital is necessary. Moreover, the facts which establish the claim should be submitted to the public for review. This will serve to assure the public of the soundness of the investment it is asked to make.

The campaign director should not be employed on the strength of hearsay evidence or of any printed matter he may issue as to his capabilities. A thorough critical investigation should be made, both of the man and of his methods.

It is indeed most appropriate to send a message of good will, encouragement and gratitude to the hospitals at this blessed season of Christmas, as the hospitals are the direct fruit of the teachings of Him who came to bring spiritual health to all and who taught the true value of corporal works of mercy.

Americans should be most grateful for the skill of the surgeons and physicians, for the tirelessness and tenderness of the nurses, and for the countless sacrifices of the general staff in our many homes of mercy, called hospitals. Let us hope that during the coming year the good work will be increased not only in the large centers of population but also in the rural districts, where additional facilities are greatly needed.

May Christ, the Great Healer, bless all engaged in hospital work and may His mercy, tenderness and sympathy be a constant example to those who have been called to assist suffering humanity.

P. T. Maldron

Bishop of Rockford.
Chairman, Department of Social Action, National Catholic Welfare Council.

The hospital's campaign committee and not the campaign specialist should hold itself responsible for the campaign, the persons conducting it, and any official statements or promises made during it.

The campaign committee should guarantee all the expenses of the campaign, and pay its director a salary. Commissions should be frowned upon. The desire to increase their income may tempt campaign specialists to secure contributions by measures that react most unfavorably upon the hospital and its place and influence in the community. Employing a director on a commission basis, moreover, gives unwilling contributors an opportunity to assert that if they contribute to the hospital during the campaign a portion of their gift will go into the pockets of the campaign specialist. Rather than have this happen they will refrain from giving altogether.

A finance committee should keep an accurate record in detail of the monies pledged, and the funds received during the campaign. For obvious reasons this should not be the responsibility of

the campaign director. At the end of the campaign the records should be audited by a certified public accountant, and the reports submitted either to the contributors or to the public at large.

It is believed that if hospitals will consider these suggestions in organizing and conducting their financial campaigns, they will have fewer failures and win many steadfast friends.

GRAVEYARDS AS MORALE BUILDERS

PLEASANT and stimulating surroundings, all will concede, are an important factor in helping the sick to get well. This unquestionable boon will be provided for the ex-soldiers in many of our government hospitals if the fourth recommendation contained in the report of the special senate committee, which has been investigating complaints of the inadequacy of soldiers' relief, is acted upon.

This recommendation provides that in all government hospitals where there is ground not in actual use for other purposes a sufficient cemetery be established for the burial of deceased, disabled veterans of the war.

Of the morale-building, health-giving quality of graveyards planted next to hospitals there can be no question. A daily view of seriate tombstones glittering in the mid-day sun or standing in ghostly array under a moonlit sky cannot but act as a tonic upon painwrecked bodies and jaded nerves. Indeed this applies with special force to our ex-soldiers, all of whom are supposed to have made death their pal in the grim conflicts of war. As the convalescent boys take their daily outdoor constitutional, what more inspiring diversion than to walk among the graves of their departed dead and meditate upon the inspiring legends on the tombstones! Could any other daily regimen be more conducive to their rapid recovery? Take as an example the Edward Hines, Jr. Hospital, with its 320 acres of ground. Fully 300 acres of this generous expanse might, with excellent psychic effect upon the ex-soldier patients, be dotted with the graves of their comrades in arms. Surely the \$250,000 which Congress has made available for beautifying the grounds of this institution could not be used to better advantage than to landscape it for a cemetery. For economy's sake at least, let our government hospital grounds serve the double purpose of housing the sick and furnishing a resting place for the dead.

In all seriousness, would not committees of the House and Senate display commendable wisdom if in the future they were to avail themselves of the technical knowledge and advice which is always at their command in the offices of the surgeons general of the Army, the Navy and the

Public Health Service when dealing with institutional medical problems of this character?

PUBLIC HOSPITAL SYSTEM OF NEW YORK UP FOR STUDY

THE organization and administration of the public hospital system of New York City has long been regarded as unsatisfactory. Of the seventeen hospitals conducted by this city, seven are administered by the department of public welfare, five by Bellevue and Allied Hospitals and five by the department of health. These three departments act for the most part independently. The result is a pronounced overlapping of functions with resulting inefficiency and waste. Tuberculosis, for example, is treated to some extent in Bellevue and Allied Hospitals, to a considerable degree in the hospitals of the department of public welfare, and finally in the hospitals of the department of health, nearly one-half of whose total number of days of treatment is supplied for the care and treatment of tuberculous patients. Four of the five hospitals in the Bellevue and Allied Hospitals group and six of the seven hospitals conducted by the department of public welfare are doing general hospital work in a way that duplicates effort.

To meet the ever-changing and increasing needs of a rapidly growing city, whose population shifts so constantly, new, and the occasional relocation of old, hospitals and dispensaries, are constantly demanded of the city, particularly in locations where private initiative is not apt to supply the need. Under the present unsatisfactory situation, however, no one department is charged with the responsibility of studying the hospital situation as a whole, in order to determine what additional and altered facilities should be provided by the city and to supervise the non-municipal hospitals in regard to such aspects of their development, location and work as may concern the city.

Various changes that have been proposed officially and unofficially since the consolidation of the Greater City, are symptomatic of the long-standing dissatisfaction with the situation. Space will not permit us to review these proposals. All point to a consolidation of the service in the interest of economy and efficiency. Up to the present, however, none of these plans have been acted upon mainly because they require radical amendment of the city charter. But a change for the better seems imminent. The Meyer committee, a joint legislative committee appointed by the state legislature of 1921 to investigate the government of the city of New York, has been looking into the question of the most desirable organization

and administration of New York City's public hospital system. It is presumed that the findings and recommendations of this committee will be turned over to the charter revision commission which was appointed by the governor of the state under authority of the state legislature, and which will probably report its recommendations to the legislative session of 1922.

The Meyer committee invited a number of individuals and agencies familiar with the hospital situation in New York to offer criticisms and suggestions, among them the New York State Board of Charities. In reply to the committee's request this board has recommended the establishment of a department of hospitals and dispensaries. The duties of the proposed new department would be to administer all of the public hospitals and dispensaries of the city of New York, now existing or to be created; to assume the duties devolving upon New York's Board of Ambulance Service; to make provision for the care of the sick poor in their homes; and finally to supervise the non-municipal hospitals, with reference to such aspects of their location, work and development as may concern the city government. This department would be administered by a single commissioner, whose qualifications should be so stated in the city charter as to insure the appointment of a person who possessed the educational attainments, technical knowledge and administrative ability which would enable him to carry on the work of the department successfully.

Some such consolidation and control as is here suggested is, it would seem, highly desirable, and should receive the hearty support of all who wish to see the public hospital system of New York City well organized.

MISS GOODRICH GIVEN DEGREE

IN NURSING circles the name of Annie W. Goodrich is one to conjure with, because she is one of the best loved leaders in the nursing profession. It is probable that Mount Holyoke College has little conception of how it has endeared itself to nurses by conferring on Miss Goodrich the honorary degree of Doctor of Science.

The celebration of Founders' Day on October 8 was made the occasion for this ceremony, and although the newspaper accounts referred to Miss Goodrich's conception and development of the Army School of Nursing as her outstanding achievement, her peace-time conquests of difficult problems in connection with the progress of nursing education are quite as fruitful a contribution to human betterment as the Army School of Nursing, brilliant and dramatic as that was.

Through the columns of *The Modern Hospital*, I send my Christmas greetings to medical officers in charge, officers, employees and patients of United States Marine and Public Health Service Hospitals; also, to the personnel and patients of all other hospitals to which *The Modern Hospital* carries its valuable information and cheerfulness from month to month.

My earnest wish is that you may be immersed in the current of Christmas joy; that all despondency will be displaced by hope; and that a Merry Christmas will be followed by a bright and happy New Year.



Surgeon General, U. S. Public Health Service.

Miss Goodrich is to be congratulated on this well-earned distinction, but even more is the nursing profession to be congratulated that she is one of them. They may with good reason be proud to have the name of such a worthy representative of the highest ideals of nursing service added to the growing list of notable women who have been singled out for such honor.

Miss Julia C. Stimson, who followed Miss Goodrich as head of the Army School, received a similar degree at the same time.

"THE SAME OLD STORY"

In speaking of hospital publicity, Ralph Welles Keeler, director of publicity of the Methodist Episcopal hospitals and homes said:

"That which is daily routine to us is often of interest to those who have never heard of it, if presented to them in an attractive way. There is a bit of philosophy for us right here in the advertisement of Associated Engravers, Incorporated, in the Advertising Club of New York City. Under the title 'The Same Old Story,' the following is printed:

"The leader of the orchestra doesn't like even the best show after the first twenty nights. He hates the comedian and the same old jokes.

"But the box office receipts pile up. The theater is crowded. The people laugh at the same old stories (or what the orchestra thinks are the same old stories.)

"So, when we are apt to grow tired of talking about real engraving service, about making the best of engravings we can and of our ideas of friendship in business—we remember that in this instance we have the viewpoint of the orchestra leader—and we keep on telling the same old story."

HOW SOME NEW YORK AND CHICAGO HOSPITALS SPENT CHRISTMAS, 1920

CUSTOM in all the large Chicago and New York hospitals decrees that Christmas every year shall be the brightest, happiest, and best of all the days of the year, but hospital officials are unanimous in saying that the Christmas of 1919 excelled all others in the spontaneous giving of money, time, and labor by hospital boards, nurses, physicians, and friends of the hospitals and in the joy experienced by both the children and the adult patients, and, incidentally, the donors.

NEW YORK CITY HOSPITAL

When you are two thousand miles away from home at Christmas, for the first time in twenty-five years, and in a city hospital at that, you wonder if you will miss the cheerful "Christmas gift" greetings and the spirit of good-will and happiness which pervades the holidays at home. However, in the New York City Hospital, there was no cause to worry, for an unusual spirit of peace on earth, good-will toward man, seemed to be thrown over all the inmates of this big institution—patients, employees, doctors, and nurses. For a little while the patients forgot their pains and aches and again enjoyed a real Christmas dinner and the coming of Santa Claus with his bag of gifts; the nurses moved with winged feet and forgot how long the day could be; the doctors hid their pill-bags and stethoscopes and helped with the decoration and entertainment.

A few days before Christmas one of the largest wards was temporarily emptied, a stage erected, and a huge Christmas tree installed, with colored lights and all the "fixings." The walking patients and those who could possibly leave their beds for a few hours assembled there for an afternoon's fun. Through the kindness of friends and officials of the hospital, some of the best vaudeville entertainers in the city came over to aid in the merry making. They were all there—the magician, the black-faced comedians, and the musicians. Santa Claus arrived on the scene, to the great delight of the children. Then that favorite of young and old, Charlie Chaplin, appeared on the screen in "Shoulder Arms." The musicians afterward went around to the wards and played for the patients who could not go to the party. Ice cream for all

did its share to complete the afternoon's enjoyment.

Do you believe in Christmas fairies? There is one that visits this hospital every year and gladdens hundreds by her coming. Long before the Great Day arrives she flutters around each hospital ward and finds out what each one desires most of all. Last year the presents arrived on Christmas eve and were delivered with the aid of the hospital officials and the social workers. The fairy gave of the best of her stores, and tried to get each patient his or her heart's desire. One little crippled lad wanted a wheel chair and on Christmas eve Santa Claus rolled in one of the best to be had. A patient in a neurological ward wanted a stuffed duck of the eating variety, and was the envy of his fellow patients when one arrived

good enough for a king to eat. The little new mother at Maternity was very pleased when her wished-for gift came—two pairs of white kid gloves. Many of the presents were very useful and added much to the comfort of the patients—warm bath-robos, shoes, coats, hot-water bags, and other things. Nor were the children forgotten; there were dolls for the girls and squeaky, noisy things for the boys, with queer objects that run on wheels, and bags of nuts, candy, and oranges for all.

The nurses, with many willing hands to assist, made their wards festive for the holidays. Bells, holly wreaths, festoons, and tiny Christmas trees made the wards quite cheerful. A huge bowl of fruit and nuts was ornamental for a while, and then was passed around to the patients. All were given new clothes, being allowed to choose their own favorite color—blue, pink, or brown. At dinner time a large table was set in

in each ward, gaily decorated with red crepe paper, and the bowl of fruit for a centerpiece. A real Christmas dinner was served, with turkey and dressing and cranberry sauce, and all the other good things. Early in the afternoon the visitors began to arrive to gladden the hearts of their friends and relatives with more gifts and cheerful greetings. The "Jesus women," as the patients call the missionaries, came with kindly words and baskets of fruit and flowers for those who had no friends. Everything combined to produce the real spirit of Christmas.



Every hospital ward has its own glittering Christmas tree, which friends and generous-spirited strangers have decked with gifts.

COOK COUNTY HOSPITAL

The same spirit of generous giving which made Christmas, 1920, a gala occasion in other hospitals was evident at Cook County Hospital. For the 1,300 wards of the county, the holiday season began on December 19, that being the last day of school. This was celebrated with a program of recitations and songs, and the little performers did their stunts in the most approved fashion, regardless of bandaged arms, legs and heads.

But even before that eventful day the gifts from the hundreds of prodigal Santas began to arrive. Never before in the history of the institution had there been so much received for distribution, and the wards kept in reserve enough to keep up with the wreckage for months to come. The plan was for social service department workers to get a list from each supervisor of the number in her section needing certain articles, and then so far as possible to fill those orders. None of the small patients cared to leave the hospital at this interesting period, even though they had sufficiently recovered to be removed. They begged to be permitted to stay and, after the festivities were over, made a solemn vow to be on hand again the next year, even if they had to get run over by a motorcycle to accomplish the feat.

And small wonder! For there were Christmas trees everywhere—upstairs, downstairs, in the corridors. There were even three out of doors on the south side between the wings—it would be easier to tell where there were none—so that the great, grim building assumed a very creditable imitation of fairyland.

Decorations were practically all made by patients, and the county furnished trees and holly wreaths. There was strong competition among the various supervisors, each making a strenuous effort to have her ward appear the most attractive. Ward 41, one of the children's wards, was, as usual, attractive. There was a little manger in one end with the Christ child and the Wise Men, and an angel or two. The children adored it.

Ward 31, which is children's surgical, had the best time. No one was very sick and their Christmas started on the afternoon before around the lovely Christmas tree in the play room, the gift of the Englewood Woman's Club. When they went to bed they refused to go to sleep until the night nurses hung their stockings, and when the nurses, singing carols, as is their yearly custom, came around about five o'clock in the morning, up they started again. They tried out everything in their possession that would make a noise, until they had to be subdued for the good of the rest of the house.

As for music, those who were privileged to listen to elaborate programs rendered by artists in the churches and elsewhere were no more favored than were the patients at the county hospital. On Christmas Eve the sweet-voiced surplined choir of the New First Church came over and sang from floor to floor. The Third Presbyterian church choir was at the other end of the building, singing its beautiful carols. The story of the Christ Child was told in song, on the violin, piano and 'cello.

Then on Christmas day, there was the wonderful turkey dinner, with mashed potatoes and one other vegetable, gravy, celery, bread, butter, coffee, pie, fruit and nuts, served at noon to everybody who was able to eat. The tables had flowers or small Christmas trees for decorations, and the bed patients' trays had napkins with Christmas colors instead of the ordinary white.

In the afternoon Mr. Zimmer had arranged for an entertainment in Ward 20, which was fitted up with a stage. Everyone in the house who could get there came

to the show. Entertainers from almost every theater in the city came and did stunts for the entertainment. Mr. Zimmer sent his piano from ward to ward so that each bed-ridden patient could have some share in the Christmas happiness.

Members of Bishop Kettler Council, Knights of Columbus, sent their glee club and a chorus of fifty voices to sing in every ward. Services were held in the beautifully decorated chapel on Christmas morning for all Catholics, and at midnight on Christmas Eve for the Episcopalians.

Dear old Santa Claus never passes up Wesley Memorial Hospital. He comes early and remains to the limit.

Christmas, New Year's Day, Thanksgiving, Hallowe'en, Fourth of July, and Memorial Day are always special occasions at Wesley. The little ones may be deprived of home and mother, but they do not lose the cheer and glad times provided by the considerate trained nurse in charge. Beautiful stories are told, recitations are given, and appropriate songs rendered. A group of nurses, especially appointed, sing Christmas carols. Of course, the climax is reached when Santa Claus appears. He is always accompanied, when visiting Wesley, by Mrs. Santa Claus. For the Christmas celebration a large ward is cleared and the room tastefully decorated with the idea of eliminating the atmosphere of the sick room as much as possible. A tall and shapely tree is provided with the usual decorations. Chairs are placed in the space about the tree, and room is provided for wheel chairs. Convalescing patients greatly enjoy the occasion and never fail to be present. The superintendent of nurses and her staff plan weeks ahead for the gay festivities of Christmas.

During Christmas week Wesley provides a Christmas tree and a party for the nurses in training, where they may for the time being forget the exacting requirements of their service to the suffering ones and join in the happy festivities of Mr. and Mrs. Santa Claus. The dispensary of the Northwestern University medical school, which is situated just next door, is also honored by an official visit from Santa Claus. He is accompanied by a group of nurses, who distribute candies and presents. The welcome on the part of the children is most hearty and is usually expressed by loud cheers, blowing of horns, and cries of "Santa! Oh Santa! Please shake hands with me."

HOSPITAL BETTERMENT IN CALIFORNIA

The League for the Conservation of Public Health in California has planned a Hospital Betterment Movement, or a "service" program for hospitals. It is, according to the *California State Journal of Medicine*, designed to bring the hospitals to the highest point of efficiency as an effective part of the program of better medicine and better health. The effort has little to do with so-called "standardization"; in fact the officers of the League believe that hospitals cannot, nor is it desirable to have them, become standardized any more than it is desirable to standardize the practice of medicine.

The good hospital must be a part of the application of the principles of science and art and economics as they enter into the practice of medicine to the prevention and cure of disease. As "personality" forms an important part of the qualification of the physician so must it of the successful hospital. This personality must be expressed in the giving of efficient, careful and sympathetic service to the sick. To make hospitals alike would be, in the opinion of the officers, to lead them toward mediocrity.

USING THE FINGERS TO CURE THE LUNGS

By H. A. PATTISON, M.D., SUPERVISOR OF MEDICAL SERVICE, NATIONAL TUBERCULOSIS ASSOCIATION, NEW YORK, N. Y.

IT HAS often been said that successful treatment of tuberculosis depends to a very large extent upon the fullest cooperation of the patient. Unless the person afflicted with the disease will follow the course of living laid down for him by his physician, his chances for recovery are much reduced, but observation in thousands of cases has shown that for the best results the patient must not merely do what he is told to do, but must do it cheerfully and willingly. How to keep the patient's mind occupied with something besides thoughts of his own condition has always been a problem which now seems to have been met in many cases by occupational therapy.

Reduced to its simplest terms, "occupational therapy" means the occupying of the hands and mind of the convalescent patient with light work which will assist in effecting a cure. Occupational therapy was used with success long before the World War broke out, but during the war period great numbers of service men sent to hospitals either because of wounds or disease naturally became subjects for this form of treatment. In the case of these men, stricken in the prime of life, occupational therapy served as a necessary means of bridging the period between their convalescence and their entrance into vocational schools which would fit them for useful positions in civil life.

Occupational therapy, speaking in a broad sense, is divided into three parts, as there are practically three parts in its remedial application. These are diversional therapy, occupational or handicraft therapy and pre-vocational therapy.

Diversional therapy comprises simple amusements which the patient can enjoy while still in bed. Games and puzzles which require skill in the use of the fingers and which divert the mind are all approved and have been used with success.

The next step is occupational or handicraft therapy. This involves the performance of definite tasks by the patient, such as the doing of useful things with woods, beads, textiles, clay and metals. In doing these things, the patient not only occupies his mind but is assisted in restoring lost and weakened function.

Industrial Recreation

Pre-vocational training is in reality the last step in occupation as a form of treatment, for this training means that the patient is employed in doing things which lead up to definite education for some industry, trade or profession.

All of these forms of occupational therapy have been called industrial recreation. This includes such forms of occupation as may be followed in some cases while the patient is still in bed. Basket-weaving, modeling, drafting, light carpentry, jewelry-making and photography are among the varieties of industrial recreation which naturally interest patients according to their tastes, and also have value as preparatory training for real work. Vocational training, as the name implies, means instruction in specialized forms of work under conditions approaching those existing in commercial institutions, and this training naturally does not come until the patient is really graduated from the ranks of the convalescent to the army of the well and strong. In fact, however, authorities do not include vocational education as a part

of occupational therapy, although one naturally is a continuation of the other.

Since the purpose of occupational therapy is to interest the patient to such an extent in what he is doing that he will not brood over his own condition, the welcome given by patients to light tasks is evidence of the way in which this treatment fulfills its mission. To take only one example, the tuberculous soldiers in the army sanatorium at Oteen, N. C., are reported to be continually demanding higher standards of work. Dr. Herbert Hall, an authority on this subject, has said: "Short of actual drudgery, the more useful the work, the better its therapeutic results, and conversely, the more trivial and valueless the nature of the work, the less effective will it be in the therapeutic sense."

Variety of Appeals

Everywhere the effort is being made to offer to patients forms of occupation which will appeal to them. Of course, there are limitations to the variety of tasks in the earlier stages of occupational therapy, but in the pre-vocational period many odd forms of light work have been introduced. The care of flowers and bee-keeping are among those which have appealed to certain patients.

The extent to which occupational therapy has been applied is shown by a summary published in June of this year by the federal board for vocational education. According to this, in 44 hospitals, public and private, exclusively for tuberculosis patients who were ex-service men, 3,281 patients were enrolled for some form of occupational therapy or vocational training. This was out of a total of 3,929 patients who were well enough for such treatment. To be sure, these government figures do not distinguish between what may be technically called vocational therapy and vocational training, but they show the recorded fact that more than 84 per cent of the men in a condition to do so have enrolled for some form of training which will keep their minds busy with things other than their condition.

Occupational therapy has been provided for patients in all the state institutions in Wisconsin. The tuberculosis associations in New Jersey, California, Minnesota, New York and other states have organizers regularly employed to introduce this form of treatment into all county tuberculosis sanatoria in those states. The use of occupational therapy by former service men placed by the federal board in private hospitals has led in many cases to the application of this treatment to other patients there. In other words, it may be said that this manner of using the fingers to cure the lungs is coming more and more into favor.

Information regarding the progress of occupational therapy is constantly being gathered and disseminated by the National Tuberculosis Association and its 1,200 state and local organizations. This is only one of the many ways in which these organizations combat the disease which killed 132,000 Americans last year. Funds to carry on this work are derived from the sale of Tuberculosis Christmas Seals and the fourteenth annual Christmas seal sale will take place in December of this year. The response of the public in purchasing these seals will determine the extent to which anti-tuberculosis work can be carried forward in 1922.

NURSING EDUCATION*

By MARTIN H. FISCHER, M.D., PROFESSOR OF PHYSIOLOGY, COLLEGE OF MEDICINE, UNIVERSITY OF CINCINNATI, CINCINNATI, OHIO

ARE we going to extremes in the matter of educating our nurses? Are we going to cast aside our three-year nursing course and adopt the new proposal, the quick and easy twelve-week course? That's the problem we have before us tonight.

Do not think that the problem concerns only doctors and hospitals. It is your problem. Some of us get through life without finding it necessary to call upon a lawyer or a minister, but every one of us sooner or later touches the doctor and the nurse. And what kind of individual are you going to permit to play with your entire capital? Should you lose your money, you can make more; but if you are robbed of your well being, your very existence is bankrupt.

The whole question is not new and, I may as well add for myself, the answer is not, either. I agree with the words of William H. Welch uttered some years ago:

"There has been at times criticism on the part even of leaders of the medical profession as to the position which the nurse desired to attain. There was a catch word at one time—one may possibly hear it today—that nurses were being over-educated. That it is possible for a nurse to know too much, to be too highly qualified on the practical, scientific and intellectual side of her profession is absurd."

The immediate cry has two sources. It is said that we have not enough nurses and that their expense places them beyond the reach of our great middle class.

The trained nurse is the exponent of a profession. The girl that touches our sick-bed today represents in training the collective and critical opinion of a half century in education. Do you honestly believe that an adequate substitute can be found for her by calling a downstairs maid, faithful for twelve weeks on the job, a nurse? The profession of the trained nurse is just like the profession of medicine. During the war there was a cry for more doctors and quickly; and the proposal was made that we cut down premedical requirements, shorten the medical curriculum and omit the compulsory internships. And yet at the same moment medical officers were telling us that the men we were sending them with all these extras attached knew not enough about fundamentals of medicine and surgery. Is the solution of any problem calling for competence ever solved by calling upon the less competent?

Nurses Becoming More Plentiful

Scarcity of nurses is not an acute disease but a chronic one. There never have been enough of the competent and the well-trained, and just now we are but emerging from a war in which the energies of any number of capable women have been diverted to factories and administrative offices. Along with the war came a pestilence. No wonder that with inadequate numbers of recruits and quadrupled needs for service, we found ourselves short. But these difficulties are passing. The hospitals this year have a full quota of pupil nurses.

The other cry is that our trained nurses are too expensive. Let us look at this, for a moment. Are we really desirous of having skilled workers labor for less than a living wage? How are we going to keep the physically, intellectually and socially fit entering the profession of

nursing if the future does not promise them even a decent livelihood? The trained nurse gets less than the school teacher and the school teacher gets less than the half-skilled worker. If we are going to set standards which will appeal only to the maid of all work we will get that kind of service and nothing better. The question has been up in medicine. It has been argued that we ought to turn out poor doctors from our medical schools for poor districts and for the country. Now it is intended that we shall furnish these poor people poor nurses. And yet the poor laugh and cry and suffer remarkably like ourselves. The only difference is that they are far more stoical. Need I comment on such injustice?

Untrained Nurse Not Cheap

Is the untrained nurse, who is to come to us cheap, really cheap? Even this "natural" "God-given" nurse with all the shortcomings of her training cannot live below a minimum wage. And when opportunity offers, her moral standards are hardly such as will keep her from taking advantage of a critical situation. During the influenza epidemic when the trained nurse was receiving her twenty-five or thirty dollars a week, the untrained did not hesitate to take forty, fifty, and seventy dollars a week. Let us have no illusions about the matter. There may be plenty of women willing to enter twelve-week courses, but as soon thereafter as possible they will pass themselves off as skilled and trained nurses and demand their wages. To call a woman a nurse is not to make her such.

Professional nursing is not peculiar to the United States, but I do believe we do it a little better than other nations. There is a reason for this. We have been a little richer but also we have been a bit more democratic and politically a bit more eager for the universal square deal. If medicine had anything to give, we felt that its blessings ought to go equally to rich and poor. We have made nursing a sister profession to medicine.

Danger in Brief Training Period

Consider for a moment what you expect of a nurse. We have gone a long way since the times when a good neighbor woman, kindly in spirit but badly educated, "set up" with an individual—and watched him die. If you know how through the application of the teachings of bacteriology the surgeon may now penetrate any portion of the body without danger of infection, you will agree with me that if you are to be the individual to be operated upon, none but a trained surgical nurse shall touch you. Are you willing to have a twelve-week nurse prepare the sutures which are to be buried in your body; or will you trust yourself or your new born child to her ministrations? And yet I say to you frankly that the surgical nurse is the easiest of all trained nurses to prepare.

It is so easy to counsel a man with tuberculosis to stop work for six months, to lie in bed, to breathe fresh air and to partake freely of milk and eggs. But who is going to see to the carrying out of these instructions, especially if the man is poor, and who will keep up his constantly sagging spirits? If you want to see hard work, watch the nurse who understandingly takes care of such a patient. Or watch her as she works through the

*Read at the Cincinnati Health Exposition, October 18, 1921.

minutes which seem like days to the man with pneumonia. To inspirit a dying man to a last fight takes all of hand and heart and soul that the best of women can give.

There is not a feature of the sick room problem that can be solved by sending into it a half-baked simpleton and calling her a nurse. Even the generous heart is not enough. Grandmothers are still willing to tend the younger generation in labor; and if you think cheap service adequate, there are still midwives to be got for ten dollars. But if you want to know how labor pains have been stilled, (Why is it that husbands no longer lie in the ground surrounded by six wives each dead with child-bed fever?) do not ask about the contributions which these, mayhap, good women have made to the subjects of anesthesia, bacteriology and surgical technique.

Must Increase Use of Hospitals

When it is contended that the worker cannot meet the financial obligations of adequate nursing service, I reply that the answer to one economic outrage is not another one. If we are already sweating the worker, let us recall our American standards and not begin to sweat the trained nurse also. As a matter of fact, ideas and movements are already active within the trained nurse group which can bring adequate nursing care to all our ill. Something like 90 per cent of nursing is now done outside the hospitals. We might begin by increasing the 10 per cent fraction and decreasing the ninety. Concentration within hospitals would mean not only better care for patients, but cheaper. At least as large a fraction of our medical patients should get into hospitals as of our surgical. But a better efficiency needs to be brought into our hospitals. There is no reason why the basic cost per patient in a hospital should exceed that of a good hotel. Let someone with initiative and love for his fellowmen come forward and show a community how it should be done.

We can begin to meet the outside problem by producing a much larger number of private duty nurses. But we are not likely to increase their number by degrading their social, economic and intellectual standards. If the number of private duty nurses remains inadequate, we can expand the excellent ideas of the district nurse, the visiting nurse and the hourly nurse. If the cost even of these is too high for the average man, let us charge it back to those who are responsible for the condition of the poor. Let us determine whether it is individual, corporate or state. There is no reason why many nurses should not be paid directly out of the public account. A community has obligations to its sick not only when they are resident in a hospital but when confined within the four walls of their own homes. We can increase, too, the number of nurses available for actual care of the sick by reducing our present reduplicated administrative staffs. There is no reason why in this city a half dozen hospitals should be running a half dozen personally conducted training schools. The fundamental education of the nurses might be given in one school, with the bedside and operating room work in the individual hospitals concerned.

There stands near Trafalgar Square in London a great monument to the men who fell for England in the Crimean War. After its erection, that monument was pushed back to give space before it to a single small figure in bronze. It is the figure of Florence Nightingale. I do not suppose that the British Government would have moved that monument if it had not felt that the work of Florence Nightingale is more significant than the 1856

Treaty of Paris. It is to knock down this figure of the woman who beat the Russians more effectively than the British army and to put in her place a good woman, perhaps, but one of no education, no character and no human understanding, that some would have us accomplish. I think that it will not be done.

SHRINERS WILL ERECT TEN HOSPITALS

What is undoubtedly the most comprehensive program for the care and treatment of crippled children ever undertaken by any fraternal order is the project of the Ancient Arabic Order Nobles of the Mystic Shrine of North America for the immediate construction of five orthopedic hospitals in various sections of the country and for the future establishment of five additional hospitals, each to be erected at the estimated cost of \$250,000.

The Shriners' original plan, in assuming paternal relations with the crippled children of the country, was to erect at St. Louis a central hospital of 150 beds in conjunction with Washington University. A survey of their prospective clientele brought results that astounded the Thirty-second Degree Masons. They learned that there are in America approximately 480,000 crippled children, one-half of whom might reasonably be expected to come within their constituency. With a single hospital of 150 beds, the trustees of the Shrine hospital program made hurried mental calculations and saw that to treat such a multitude of cripples would require something near 190 years.

Faced by the enormity of their task, the Shriners determined to continue their plans for the St. Louis institution on a lesser scale and to build as many smaller hospitals in other sections of the country as the money available would finance. The Shrine building program, as decided upon in late September, calls for the immediate construction of hospitals in the following cities:

St. Louis, an eighty bed hospital, for which \$150,000 is allowed for grounds; \$300,000 for buildings; and \$50,000 for equipment.

San Francisco, a fifty bed hospital to cost not more than \$250,000 when fully equipped.

Shreveport, La., a \$250,000 institution.

Montreal, Canada, a fifty bed unit at \$250,000.

St. Paul and Minneapolis, a similar institution.

The secondary building program of the order, to be undertaken as quickly as funds are available, calls for the establishment of fifty bed type of institution at Portland, Ore., one in some city in New England, Virginia, Pennsylvania and the Rocky Mountain states. The first one of these hospitals will probably be begun in 1922. Work on the five original hospitals will be well under way within a few months.

The one-story type of building, much in use for orthopedic hospitals for children, has been decided upon by the Shrine hospital trustees. Administration buildings of each unit will be the Moorish type of architecture with wards on either side in a design that will identify them at a glance as a Shrine center of interest. Shrubbery and flower beds on the grounds will be arranged to represent Shrine emblems, according to the plans, but the trustees are said to be anxious that efficiency will not be sacrificed for ornamental architecture.

Trustees of the hospital program are: Sam P. Cochran of Dallas, Tex.; W. Freedland Kendrick of Philadelphia, Pa.; Dr. Oscar M. Lanstrum, Helena, Mont.; Bishop Frederic W. Keator of Tacoma, Wash. John D. McGilvray of San Francisco, Cal.; Philip D. Gordon of Montreal, Can.; Forrest Adair of Atlanta, Ga.

REDUCING NOISE TO THE MINIMUM

IT IS a fact which most hospital people must know, but unfortunately few stop to think about, that the noise of the modern structure with its reinforced concrete and steel construction is one of the most trying of hospital problems today. It is absolutely necessary to bring interior disturbances down to a minimum. Mr. Frank E. Chapman, superintendent of Mount Sinai Hospital, Cleveland, Ohio, found that when standing in the proper place on the first floor of a modern building one can hear the nurses' call buzzer sound on the third and fourth floors. Imagine what the slamming of doors, the dropping of dishes, and the heavy tread of feet in the corridors must mean, in the aggregate, to the sick person!

Mount Sinai Hospital had tried, it thought, every means of conquering the noise horror. It had "reprimanded, dismissed, suspended, discussed, and cussed," without result. Finally someone conceived the truly brilliant idea of popularizing the idea by forming a "Society for the Prevention of Needless Noise." The society issued a number of bulletins, some of which are reproduced here, and also

appointed monitors whose duty it was to "quiet all unnecessary noise in as diplomatic a manner as possible, making report of the most flagrant cases." They turned in a daily report on a regular form which provided place for the recording of the time, place, and character of the offense, the name and the "response" of the offender. The individual was to be approached by a tap on the shoulder and the courteous reminder, "Remember our guests."

The plan worked like a charm. The monitors and bulletins were far more successful than it had been believed possible. Of course, noise has not been eliminated from the hospital, but it has been reduced to such an extent that as one client of the hospital remarked, "You wouldn't believe it is the same place."

It has been necessary to re-issue one or two of the bulletins from time to time as a reminder, but they have always met with good response. There is no question but that the society is a success; would it not be well to form such a one in your hospital?

BULLETIN No. 3

A woodpecker pecks
Out a great many specks
Of sawdust
When building a hut;
He works like a nigger
To make the hole bigger
He's sore if
His cutter won't cut.
He don't bother with plans
Of cheap artisans,
But there's one thing
Can rightly be said:
The whole excavation
Has this explanation—
He builds it
By
Using
His
Head

Use your *HEAD*; hold your *TONGUE*, and make Mount Sinai a *QUIET* Hospital, in which to get *WELL*.

BULLETIN No. 6

RUBBER HEELS

We have no stock in the rubber business, but we place great deal of stock in rubber heels. *GET INTO A PAIR* and they will act as shock absorbers both to you and the ears of our guests.

BULLETIN No. 9

Supplementing the system of monitors now in effect, we are asking *EACH OF YOU* to serve as a committee of one in an attempt to reach a very small percentage of members and frequenters of our Institution who have not yet been reached by the "Gospel of Quiet."

You know some folks have to be lifted, like so many pieces of pig-iron. Their attitude towards our Campaign is just like the "darn-you-make-me-smile" spirit which they take to a comedy at the theater.

Please make it your business to go to these folks whenever they make Needless Noise and if they do not understand what "please-be-considerate-of-our-guests" means, just kick them on the shins and say, "Where d'you get that stuff—don't you know you're in a hospital?"

BULLETIN No. 5

The vogue of the Sinclair Lewis novel is recognition that his "Main Street" runs through thousands of American towns.

Stereotyped uniformity as the movement for standardization of good hospital methods grows and develops, tends to make each hospital the exact picture of every other hospital.

The only way to breathe the fresh air of individualism is to *EXCEL*,—to be the *BEST*.

Mount Sinai has the reputation for being the *BEST* in many ways and we have now reached the place where we are as good as the best in the elimination of "Needless Noise." Let us now put the "PUNCH" into our Silence Campaign in spite of Prohibition and become "The Hospital where Needless Noise does not Exist."

PUT THESE WORDS TO MUSIC AND SEE HOW YOU LIKE IT.

BULLETIN No. 11

"THE WORST BLOW TO PROGRESS WOULD BE TO SACRIFICE THE PROGRESS OF THE PAST"

When Johnnie was asked to leave a note where Mr. Jones would be sure to get it, he stuck a pin through it and laid it on the seat of Mr. Jones' chair.

We have fulfilled our purpose as the Society for the Prevention of Needless Noise, and with this issue, will suspend the publication of bulletins for the present.

Please consider this bulletin left for you just as Johnnie left the note for Mr. Jones.

If the future should necessitate a reminder for you, to "please-be-considerate-of-our-guests," will you be good enough to drag out this bulletin, read the first paragraph and "THINK IT OVER"?

AU REVOIR.

OVERCOMING DIFFICULTIES AT A SMALL HOSPITAL

BY F. S. WRIGHT, M.D., BELLAIRE, OHIO

IN OCTOBER, 1916, in the City of Bellaire, Belmont County, Ohio, a municipality of approximately 16,000 inhabitants, the Bellaire City Hospital of fifty beds was completed and opened for the reception of patients.

Due to the large number of industrial accidents and the necessity of transportation of the seriously injured to the nearest hospital six miles distant, over rough roads, the public realized that a hospital was an essential adjunct to the community and the money necessary to erect and start in operation such an institution was raised almost entirely from individual subscriptions. With the opening of the institution however, a debt had developed and has remained to the present time.

Could Not Employ Proper Personnel

The development of the deficit in funds curtailed to a great extent the employment of an administrative personnel, competent in every way of building up the institution from the beginning, many obstacles have been encountered which seemed almost insurmountable.

This being the first institution of its kind, the public, in-so-far as they had furnished the financial backing, felt that they were entitled to perfect freedom as regards the institution, feeling free to visit patients at any time of day and night, demanding their presence at surgical procedures, criticising the treatment of the medical and nursing personnel, and in many ways hindering to such an extent the efforts on behalf of the board of trustees, the administrative personnel, the nursing staff and the visiting physicians and surgeons that the morale of these latter bodies was naturally lowered. This was true to such a degree that a reaction on behalf of the patients and a consequent inevitable reaction on behalf of the general public against the institution followed.

This sentiment reached a climax during the war and the epidemic of influenza, when every available space, including nurses' quarters, was utilized for patients. Due to the lack of trained nurses, volunteers did most of the nursing and were allowed free access to the institution, as a result of which scientific treatment and nursing was an impossibility. Control by the administrative personnel and board of trustees was lost to a great extent, all of which was found to react on the most important factor in an institution—the patient—and incidentally following this public opinion was decided against the hospital.

Stood Outside Looking In

During 1920 the board of trustees and the attending physicians and surgeons, realizing the defects of the institution and the "poor hospital service of same," and realizing as Dr. Warner says, that "There is no gain in having everybody outside the institution see the defects," proceeded to look at the institution as others were looking at it, and talk about it with others. Summing up the result of knowledge obtained with the past personal experience it was decided that radical changes must be brought about. An attempt was made to establish a "line of communication" with other institutions so that their policies and methods could be investigated and a future course mapped out.

One of the essentials learned was that there must be an administrative head of the institution, one capable of finding out its real problems, capable of keeping himself

and the hospital informed, out of the rut, up-to-date, and efficient—no matter what difficulties beset them; and also that a large amount of brain energy and effort was absolutely necessary.

Proper Superintendent Obtained

In January, 1921, such an administrative head was obtained, and in due time properly trained and competent professional and other attendants have followed. Lines of communication have been established with the American Hospital Association, and the American College of Surgeons, and I might say at this time that one of the greatest stimulations to the board of trustees and the visiting physicians and surgeons for developing efficiency was the visit of the representatives from these organizations who pointed out the defects and the great importance of rectifying them.

Shortly after this time the West Virginia State Sectional Meeting of the American College of Surgeons was held in a near-by city and a large proportion of the board of trustees and staff of the institution attended these meetings; and as a result of knowledge obtained there, and the efficient administration of the superintendent, the result has been that a nurses' home has been obtained, equipped and placed in running order, giving the necessary things as required for the health, comfort and efficiency of the nursing staff, together with facilities for teaching. An x-ray laboratory has been equipped and developed to care for all fluoroscopic and photographic work (financially backed by the visiting physicians and surgeons until self supporting). At the date of this writing a general laboratory is in the process of construction and should be in operation within two months' time, capable of studying bacteriological, serological and pathological material together with all routine laboratory analysis.

In April, 1921, the physicians and surgeons working in the institution organized as an open staff and since April monthly staff meetings have been held.

In order to enlist the confidence and interest of the public a pre-natal and pre-school age clinic will shortly be held at the hospital.

To summarize the difficulties of constructing and starting in operation a small hospital, establishing and maintaining "The Minimum Standard," would say:

- (1) The development of an overhanging debt at the beginning, this debt curtailing the employment of efficient administrative personnel.
- (2) Difficulty in obtaining pupil nurses, necessitating large salaries for trained ones.
- (3) Lack of cooperation of all immediately connected.
- (4) Difficulty in obtaining and holding public support.

COUNTY SHIFTS BURDEN TO STATE

It seems to be a general practice, in communities where the state's care of its wards is better than the care given by the county to its indigent population, for the county to shift part of its burden onto the state. It commits individuals not because they are insane but because they are sick or troublesome, or the proper medical equipment is not at hand. This may be right from a humanitarian standpoint, but it overtaxes the institutions of the state, and tends to a deterioration in state service.

IS THE ADMINISTRATION OF ANESTHETICS A ROUTINE PROCEDURE?

Whether any nurse or doctor, or even an intelligent layman with certain fundamental instruction, can administer anesthetic agents satisfactorily, has been the subject of much comment following the recent report of the Ohio Committee of Anesthesia. The committee, which was appointed by the council of the Ohio State Medical Association, answered the question in the affirmative and its action was later repudiated by the Ohio association through its House of Delegates.

Three men of note in the medical profession have added their views on the question to those published in the September issue of THE MODERN HOSPITAL. Two of the three stand with the Ohio State Medical Association in opposing the nurse or lay anesthetist and the third believes with the committee that the procedure may be regarded as routine.—EDITOR.

THE report of the Ohio Committee on Anesthesia does not find support in Dr. Paluel J. Flagg of New York City who thinks that this department will accomplish nothing in the way of scientific research and discovery so long as it is under lay control. He writes:

Nurse Anesthesia Not Ideal

"Teaching clinics are expected to provide ideals for the remainder of the profession to follow. Nurse anesthesia is not ideal and never can become so.

"The profession looks to the large clinic for the best in every sphere of medical activity. This is found, as a rule, with the single exception of the Department of Anesthesia. The anesthetic technician which visitors observe sets the pace for the anesthesia administered elsewhere. The result is the relegation of anesthesia to the hands of the suburban nurse whose experience is almost nothing and whose confidence is unlimited.

"A department of anesthesia under lay control is, by the very nature of its personnel, incapable of scientific research and discovery. The clinic surgeons and housemen have had no experience in the administration of anesthetics and consequently have no practical judgment to pass on the anesthesia which is administered for them. Indeed, they cannot afford to lose caste among their fellows by showing too much interest in work which a nurse is expected to perform to every satisfaction.

"The recent enthusiasm for local, spinal and regional anesthesia in some clinics would appear to be a formal acknowledgment of the shortcomings of the general anesthesia available where anesthesia is administered by non-medical persons.

"However opposed one's views are regarding the qualifications necessary to enable one to administer anesthetics, there is no necessity whatever of allowing the matter to lose its academic dignity and to confuse the issue, 'which is, and must ever be, the ultimate good of the patient.' 'The friction of men's minds, not men's passions, makes the sparks of truth to scintillate.' Indeed, one of the pleasantest occasions which the writer ever experienced was spent with a charming young lady anesthetist who called to ask for a few directions as to how to give ether. For two hours we talked of everything from Texas steers to chop suey, anesthesia having proved a bit technical after the first two minutes."

From Dr. A. B. Denison, assistant director the Lake-

side Hospital at Cleveland, comes the following opinion:

Must Not Divide Responsibility

"In general, my ideas regarding the administration of anesthetics coincide with those of the Ohio Committee on Anesthesia of the State Medical Association.

"The basis of my thinking this is primarily the fact that under all circumstances the anesthetic and the person administering the anesthetic are the responsibility of the operating surgeon and that this responsibility cannot be delegated to another person. It seems to me that this is exactly parallel with the responsibility of the surgeon for his assistant in the operation and it also seems reasonable to assume that the anesthetist is an assistant of the surgeon.

"I believe, also, that the surgeon performing the operation can, at all times, give a perfectly competent appreciation of the state of the anesthetic from the general behavior of the patient and, since this is true, it seems that the surgeon could conceivably manage the anesthetic as well as the operation. Under these circumstances, the administration of the anesthetic does become a routine procedure which could be administered by anyone having a reasonable amount of instruction in the administration of anesthetics."

Dr. William L. Soule, anesthetist of the Cornell Division of the New York Hospital, strongly advocates the administration of anesthesia by specially trained doctors. He writes as follows:

"Learning that you have in view a symposium on anesthesia and anesthetists, with special reference to the report of the Ohio Committee, I take this opportunity to relieve my mind of a few thoughts and opinions.

"According to the Journal of the A. M. A., 'the committee regards the administrations of anesthetic agents as being almost entirely a routine procedure and something which can be done by any intelligent physician or nurse, even by a layman who has had a reasonable amount of instruction in their administration.'

"Just Pour on the Ether"

"This position reminds me of the remark made by a certain house surgeon, when I spoke of teaching a junior intern to give anesthetics. He said: 'I didn't know anyone had to be taught to give an anesthetic. I thought you just placed the mask over the patient's face and poured on the ether.' To one who has been through the agonies of learning to give anesthetics properly and is constantly instructing others in the art, such views of course seem absurd, and the fact that they are held, in a modified form, perhaps, by so many who ought to know better is not flattering or encouraging to those who would like to see anesthesia placed on a better footing. To be sure, ether is almost fool-proof, and gas and chloroform, while more dangerous, have really a very low mortality, so that nearly every patient survives even an atrocious anesthesia. Subsequent complications are due to so many causes, that, with the exception of conjunctivitis and the aspiration of foreign bodies, it is difficult to say positively what ones the anesthesia is responsible for.

"The fact that so many anesthesia are badly conducted is proof in itself that their proper handling requires a high degree of skill. To put the patient to sleep hu-

manely rather than cruelly, to bring about sufficient relaxation, with a minimum of the toxic drug, to maintain an approximately normal color, above all, to judge accurately the depth of narcosis and the patient's condition—these are accomplishments which depend on sound training and long experience. Even then, one sometimes meets with a case which baffles his best efforts, and strikes his self-esteem a crushing blow.

Doctors Not Interested

"The question, 'Should a nurse give anesthetics?' may be answered by the question, 'Should a nurse attend confinement cases?' In all probability a nurse with six months' good training could take care of a normal labor case as well as the average general practitioner, perhaps as well as a specialist. In fact, the midwife is a recognized institution in some countries, and is not unknown in our own. Practically every intelligent woman, however, expects, as a matter of course, to be attended in her confinement by a medical man or woman, and there is an ample supply of such to choose from, except in the smaller towns, where the choice is more limited. As far as I am aware there is no movement in existence in favor of employing nurse obstetricians.

"With the nurse anesthetist, the case is different. The main reason for her existence is the fact that so many of both profession and laity are satisfied with her. Even those of us who object to her are forced to admit that she is, to a certain extent, a necessary evil. In New York City, for example, if all the nurse anesthetists were to go on a strike it is doubtful if competent members of the medical profession could be found to take their places permanently, except for a higher remuneration than the hospital can or will afford.

In the future conditions may change, and the nurse anesthetist gradually go the way of the midwife. Her retirement, however, is delayed by the reluctance of promising young doctors to take up so narrow a specialty as anesthesia, and by the strong bias in her favor on the part of certain members of the profession in high standing."

FOCH AT HOSPITAL DEDICATION

Dedicatory exercises at the Edward Hines, Jr., Hospital at Broadview, Ill., took place Sunday, November 6, with Marshal Foch, generalissimo of the allied armies, as guest of honor. The dedication was in charge of the American Legion, with State Commander W. R. McCauley of Illinois presiding and with National Commander Hanford MacNider among the speakers.

Marshal Foch unveiled the portrait in oil of Lieutenant Hines, who died in France while in the service of his country. Two flags, the French tricolor and the American stars and stripes, draped the gold frame of the picture, which hangs in the administration building of the hospital.

At a spot on the spacious grounds of the government hospital, ceremonies took place while above the platform aviators circled and dropped flowers.

Miss Margaret Anglin, the actress, dramatically recited in French a poem by Jules Bois as a part of the program. Addresses were then made by the national and state commanders of the American Legion, by Senator Medill McCormick of Illinois, and finally Marshal Ferdinand Foch of France was presented. The marshal did not speak, but following the exercises made a tour of inspection of the hospital, where he patted the heads of many patients and addressed cheering words to them in French.

"The marshal wishes to say," said his interpreter to the disabled veterans, "that he is glad to be with you and remembers the days when he was with you on the other side. When he called on you for something then, you did it, and if there is anything he can do for you now, he will do it." Marshal Foch also greeted Chief Nurse Mona Charles, whom he had met in Chalons while she was on active duty.

LIBRARY HAS GUESTS FROM HOLLAND

Dr. William Vos, superintendent of the municipal Zuider Ziekenhuis (Southern Hospital) and Geneesheer-Directeur van de Psychiatrische Inrichting Maasoord der Gemeente, and Mr. Jan G. Snuif, architect, both of Rotterdam, Holland, visited the Hospital Library and Service Bureau in Chicago November 1. The Maasoord is a hospital of nervous and mental diseases. These gentlemen have recently come to this country to study hospitals and have spent some time in Boston, New York, Buffalo, Cleveland, Detroit, Chicago, Rochester, Minn., and will then stop in Cincinnati, back to New York and home to Holland. They are planning to build a new hospital in Rotterdam of approximately 1,300 beds. Their old hospital was built in 1850 and is now the oldest hospital in that country. The new hospital will care for practically all types of cases save pediatric, since there are two other hospitals in Rotterdam which care exclusively for children.

JOURNAL APPEARS UNDER NEW TITLE

Announcement has been made of the change in title of the British journal, *The Hospital*, to *The Hospital and Health Review*. The first issue of the journal under its new name is now from the press. The purpose of the change in title, as given by its publishers, is to make its material not only of appeal to those interested in the hospital and in public health services but to reach "everyone who realizes the importance of the teaching and practice of health and who has grasped to its fullest significance the old proverb, 'Prevention is better than cure.'"

With the beginning of the new series, the magazine announces that it will include within its sphere the various aspects of public and personal health, preventive and curative medicine, and the general well-being of the people.

COLORADO BECOMES BRANCH OF A. H. A.

With the recognition of the Colorado Hospital Association as a branch of the American Hospital Association at the West Baden conference, the fifth geographical section of the national organization has been formed. Officers of the Colorado association, to which 226 hospitals are eligible for membership, are: President, Dr. Richard W. Corwin, chief surgeon, Minnequa Hospital, Pueblo; vice-president, George Holden of Denver; and executive secretary, Pliny Clark. Three meetings are to be held annually.

TRUSTEES' SECTION FORMED

The trustees of the American Hospital Association at the close of the West Baden conference voted that a section be formed for the discussion of hospital problems within the scope of the function of trustees. The conference next year will have such a section. Fifteen trustees attended the 1921 conference.

WHERE TO GO FOR MONEY IN ORGANIZED WORK FOR THE SICK *

By RICHARD M. BRADLEY TRUSTEE, THOMAS THOMPSON TRUST, BOSTON, MASS

THE organized service which the general public requires in connection with sickness and maternity has of late years been found to cover more and more new fields of effort, and has been found to require for its satisfactory accomplishment an increasing amount of specialized work, often involving expensive building and equipment, and calling for a continually enlarging personnel of workers.

While from these causes there comes an imperative call for much new money, at the same time the old work is costing much more than ever before. Meanwhile the supporters of our hospital and nursing work find their funds reduced by high taxation and business reaction, and are subjected to additional calls for assistance from all quarters of the world.

It is not to be wondered at that many old and tried institutions are finding it hard to carry on. Simultaneously with all this, an awakened public interest is finding itself deeply and fundamentally dissatisfied with much of this service as it has existed in the past, both because the service they have learned to want is insufficient and because of its charitable character. We therefore hear calls for state subsidies, state insurance, and public control of work that has hitherto been left to individual workers, or to self-perpetuating privately controlled philanthropic bodies.

This dissatisfaction may be encouraged by demagogues and self-seekers, but it has a real basis in defects that are only too manifest.

A house to house canvass of a cross section of the people taken almost anywhere in country or city, showing what has actually happened to the people in sickness and maternity, will convince the most skeptical that there is a radical maladjustment between the people and the service that they should get, and that the machinery for getting the people to the service and the service to the people is not working satisfactorily.

Moreover, no one who has realized the honest repugnance felt by the ordinary plain citizen for the charitable or semi-charitable methods connected with much of the only organized help available, can doubt the sincerity of those who are calling for something different and better.

We can sum up these complaints by saying that while technique is constantly being bettered and individual work in medicine, surgery and nursing is constantly improving, the application to the people of the knowledge and skill thus acquired is failing in efficiency.

This state of affairs is bringing a call for various remedies that are probably worse than the disease, and before we drift further into perilous waters, may it not

Where should the hospital go for money? To the consumer, says Mr. Bradley. "It is about time for us to undertake to 'sell' the necessary organized service, nursing, hospital, and otherwise to the consumer, and not to somebody else, and to undertake to do this on sound business and financial lines suited to the needs and nature of emergency service. The financial and business failure of our so-called system is not that of the professional workers in their own proper field, but of the business and financial men connected with this work who are failing to give it their business brains. It is a strange phenomenon that these men, in this connection, pursue methods that, as business and financial methods for accomplishing the purposes intended, are unworthy of comparison with the lowest standards of any other field of business efforts. They give their business brains to other things and reserve their emotions for hospitals."

be well for us to ask ourselves whether this palpable failure of satisfactory accomplishment in what is one of the most important fields of human effort, is due to the peculiar nature of the work or to our own present methods of trying to accomplish that work.

Why is it that the great and important industry of caring for sickness and maternity should be in such a condition of unsatisfactory accomplishment, and of financial distress, that government operation and resort to the tax payer should, to many persons, present an

attractive short cut to better things?

Why should this be the case when not only are our public health officers fully occupied with the enlarged duties of their original field, but the public has just become pretty well convinced that in almost all other lines of human enterprise the extension of government effort is to be avoided wherever possible? Why is private enterprise in this particular field so inadequate, and so embarrassed financially that increased government work is urged as a desirable alternative?

It is my conviction after a long experience in trying to get things done by organized service for the sick, that this failure is not due to the peculiar nature of the service to be done, but to the peculiarly unsound way in which it is being done on its financial and business side. We have here what would be an absurdity were it not too often tragic in its results. We see a rich nation needing to have done a large amount of service, in connection with sickness and maternity. This work is perhaps the most important of all human services. It is a service that the nation evidently cannot afford not to have done; yet that service is being done in a most insufficient manner. We hear constant complaints that there is not enough money for it, while at the same time vastly greater amounts of money are being drawn from the pockets of the people for amusements, luxuries, and other things that are comparatively of little importance.

While technical efficiency in medicine, surgery and nursing is constantly increasing, we see for whole sections of the population the application of that improved service to actual cases becoming less and less efficient, while for other large portions of the people progress is fatally slow in getting the service to the cases, or the cases to the service.

In this state of affairs we hear the call for two chief remedies, namely, a more extended resort to the government and to the tax payer, and greater contributions from the philanthropist.

Consumer Should Pay for Service

It is my suggestion that for a large portion of this problem neither of these methods is the true way out, and

*Read at the Twenty-third Annual Conference of the American Hospital Association, West Baden, Sept. 12-16, 1921.

that the true way out is what has proved the normal, ordinary, and effective way for nearly every other organized effort to serve the public's needs.

That way is to expect financial support from the consumer, or, in other words, to offer the person to be served the service that he needs in such a form that he can pay for it, and to require him to pay for it.

To use a common business expression, it is about time for us to undertake to "sell" the necessary organized service, nursing, hospital, and otherwise, to the consumer, and not to somebody else, and to undertake to do this on sound business and financial lines suited to the needs and nature of emergency service.

The financial and business failure of our so-called system is not that of the professional workers in their own proper field, but of the business and financial men connected with this work who are failing to give it their business brains. It is a strange phenomenon that these men in this connection, pursue methods that, as business and financial methods for accomplishing the purposes intended, are unworthy of comparison with the lowest standards of any other field of business effort.

It is true that of late years there has been some progress in accounting and in administrative economics, though there is room for much more, but this is not the fundamental trouble.

That fundamental trouble has its origin in the fact that nursing and hospital work was originally organized to aid the pauper classes, and is still conducted with traditions and methods suited to the pauper and not to the people. These pauper classes were in former days regarded as a large and necessary part of every properly constituted community, and their existence, in the eyes of many good and devout people, was supposed to be called for by a sort of divine decree, declaring that poverty and dependence are a necessary factor in the production of benevolence.

Pauper Class May Be Made Small Part of Whole

The study of social science, and a more enlightened social and industrial system, has brought us to see that in this country at least this dependent class can be reduced to a comparatively small proportion of the whole, and it is neither necessary nor desirable to make that class a determining factor in the organized service of the sick. Old ideas, however, die hard, and the idea still holds sway that in connection with this work we are justified in the unnecessary infliction of benevolence upon our fellow beings, which act I sincerely hope will sometime be promoted to its proper place among the deadly sins since it is as bad morally as it is financially.

At the root of our inefficiency is this medieval idea that charity is a controlling factor in organized therapeutics, together with the idea that the service of the sick and suffering, or of the helpless mother and child is something so important and so appealing that the application of ordinary business method and common sense to its relief is a profanation.

I read only yesterday of some "big hearted man" who had endowed a great specialized hospital where none but those unable to pay were to be admitted, as if disease and suffering were an exclusive possession of poverty, and as if his self-supporting fellow citizens had no need of high organized service. The foundation provisions of some of our oldest hospitals are permeated with this same error, which has sapped their vitality and limited their usefulness to an untold extent. This provision of hospital and nursing service exclusively, or primarily, for the pauper has been modified nowadays into the "pay what you feel like" method, which is erroneously supposed to dispel the atmosphere of pauperization, but largely fails

in extending needed service to the independent classes. Morally, it is rather worse than the exclusively charitable method, because it is not straightforward; financially, it is also a failure.

Citizen Wants to Pay for What He Gets

Now what the ordinary citizen calls for is neither charity nor indulgence. What he needs and wants is a pay envelope or a salary check sufficient to meet his daily needs, with a sufficient margin for emergencies, and he needs to have his emergencies so financed that he can pay for them from that margin. He has full appreciation for the philanthropic endowment that makes possible the great school, university, or hospital, or nursing organization, with a high standard of service open to the people on equal terms, but when he takes that service he wishes to go to the hospital, or to the nursing service station, as well as to the school, or to the university, with his head up, and on the basis of self-respecting equality, with no favors asked.

What is it that is necessary in order to enable him to buy this service in this way? Simply the recognition that it is *emergency* service and that we must finance it accordingly on the benefit payment or insurance basis, as all such things must be financed if the ordinary consumer is to pay for them.

Disease and sickness are not expenses that come with regularity like taxes, rent and food. They strike here and there, but owing to the philanthropic fog that has clouded our financial intellects in this connection, we as a rule make no provision for that fact. If a salaried man or mechanic loses his house by fire and has no insurance, he is pitied for a fool by his neighbors, because they are educated to use fire insurance, but let him have two or three capital operations, or a severe epidemic in his family, and it is treated as an act of God, the probability of which apparently no human wisdom could possibly have foreseen. He must either partake of charity in some shape or suffer unassisted. There is no systematic effort to find out what it costs to give him this service and to offer him insurance against that cost. Yet such things are just as certain to occur as fire, and many of them are less preventable.

Sell It in Form of Benefit Payments

The way out for our own organized services, both nursing and hospital, if they would serve the whole people, is to put this emergency service of theirs into such shape that the people can pay for it; in other words, to sell it to the consumers, in the form of benefit payments for hospital and nursing service.

There is plenty of money in the country for repairing a broken down motor and there is good service for that purpose on nearly every corner, for the simple reason that those who furnish it are able to do so since they get themselves paid for it.

I respectfully suggest that the same principle be applied to broken down bodies, and that you get your trustees, and committees, to diminish the swelling of their philanthropic pride, and apply a small portion of their good business brains to getting more of your expenses paid by the consumer through benefit payments and proper financing for emergency work. Make them get to work and sell your hospitals, and your nursing, to your consumer in benefit payments. This is no pipe dream, it is done for nursing by the Metropolitan Insurance Company for some of the needs of our very poorest, out of their pockets. It has been done for years in some countries by nursing benefit payments for associate members that cut the ordinary fee in two for such members, at the

expense, one of the founders told me, equal to the cost of a couple of dozen or so drinks per man. The same thing can be done here, and it can be done just as well for many other emergencies, such as capital operations, with a still larger portion of the cost paid through benefit payments, for people don't indulge in capital operations, as they do in nursing, for the sake of mere comfort.

Don't let your trustees potter around trying to get a lot of elaborate statistics as a basis for benefit payments. Take a few hundred families and make up an offer of this emergency service that they will probably need, estimating its probable cost, as best you can, and make your trustees underwrite your guess. Get your system going and you will soon enough find where it comes out in practice. Don't worry if you don't get many buyers at first. Put your cost accountants at work and find out what is the reasonable cost of every piece of service you do, and charge for it. Show what it will cost with benefit payments and without. Then if there is trouble, you will be able to show what your benefit payments can do.

This kind of dealing with Mr. Ordinary Citizen will be better for his soul, and he will respect and like you all the better for it.

Special Funds for Real Dependents

Your real dependents who cannot pay benefits should be financed from special funds treating dependence rather than disease, in a way distinct from the independents, and incidentally you will find what are your parasite, underpaid industries whose sick employees come on the public charge. There will still be plenty of scope for your philanthropists in taking care of these dependents, if your benefactors are not interested in enabling high standard service for all. Incidentally, in furnishing better service for all, you will be able to furnish better service even for the paupers. There is more money for your work in the pockets of the people than anywhere else. Go after it.

I am aware that in what I have said I am addressing a body of very busy people, whose greatest interest is in things that are not financial. As a class, you attend to financial things only when you have to, and you do it merely because you are not able to do your work from lack of money.

This sermon I have tried to preach, like many other sermons, is needed most by the people who are not in church. Therefore I ask you to pass it on. It is needed by those important bodies—your trustees—who, as a class, don't attend hospital meetings, but give their business brains to other things, and reserve their philanthropic emotions for their hospitals. What is more needed by the hospitals, and other organizations for the sick, is their business brains, and therefore I am presenting you with this short discourse as a testimony of a business man, to the effect that it is the business side of your proposition that is weak, and that it behooves you to get the business side of your hospitals to sit up and pay attention to this subject.

You cannot, many of you, run hospitals and start a financial enterprise at the same time, but it is possible for you to get after the financial members of your board and present this testimony, to the effect that up to the present date their financial methods are not worthy of them, and because those methods are not up to ordinary business standards, their whole enterprise is threatened with failure.

Many of your trustees can sell almost anything to the people when they try, and they can sell them your hospitals, if they will take the time and trouble, for the

goods in this case are worth more than the money they cost, and they have not even attempted to reach the real customer—the consumer. I take the liberty of advising you to tell them this and not to give them any peace until they really wake up and take hold of it.

CELEBRATES 150TH ANNIVERSARY

The Society of the New York Hospital, the second oldest institution of its kind in the United States, which received its royal charter in 1771 from King George the Third of England, celebrated its 150th anniversary in October. Commemorative exercises took place in Trinity Church, where the hospital was founded, and were attended by more than 1,000 physicians, surgeons, nurses, the governors of the hospital and their friends. Gov. Nathan L. Miller, Elihu Root, Bishop William T. Manning and Edward W. Sheldon, president of the society, delivered addresses.

After a prayer by Bishop Manning, the ancient church building was turned over to the hospital, Mr. Sheldon presiding. An historical address on the hospital was made by Mr. Sheldon, who traced the activities of the institution from the day in 1769 when Dr. Samuel Bard, one of the distinguished physicians of the Colonial period, arose in Trinity Church at the graduating exercises of the medical school of King's College, now Columbia University, and made a strong appeal for the establishment of a public hospital in New York City, to the present day. Dr. Bard's suggestion was immediately followed by a collection, to which the governor of the Province of New York subscribed, and thus was started the hospital.

The hospital was completed, after a fire had previously destroyed it, just before the Revolutionary War broke out, Mr. Sheldon related, and shortly afterwards it was taken over by the British troops and used as a British hospital. He stressed the great work of Bard, Hosack, Willard Parker, Wright Post, Weir, William T. Bull and other physicians and surgeons on early staffs of the hospital.

In enumerating achievements of the institution, Mr. Sheldon spoke of the Dr. Valentine Seaman, who went to London at the time of Jenner's great discovery and returned immediately to New York, where he demonstrated for the first time the vaccination for small-pox. He related how one doctor, thirty years before Lister's great discovery, worked on a similar proposition at the New York Hospital and told of the many new operations that were recorded there. He said that the New York Hospital, during the eighteenth and nineteenth centuries had been the beacon from which all the United States received its medical and surgical light, and read extracts from reports of doctors made fifty and sixty years ago stating that it was the greatest medical school and center in the country.

The institution has treated 2,015,000 patients since it was founded, Mr. Sheldon declared, a much larger number than has been cared for by any other hospital in the country with the possible exception of the Pennsylvania Hospital in Philadelphia.

Governor Miller spoke on the great work being done at Bloomingdale Hospital and said that Bloomingdale had pointed the way for the state. He voiced approval of its occupational therapy department and declared that it was the foremost of its kind in the country.

Elihu Root, who closed the exercises, said that while the names of the doctors who were associated with the hospital even thirty and forty years ago are now forgotten, the hospital today is a living monument to their work and to that of all of those who have gone before.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,

Director, Department of Nursing Education, College for Women,
Western Reserve University, Cleveland, Ohio

PUTTING THE HOME TOUCH INTO THE CHRISTMAS OF THE STUDENT NURSE

Just how to send scurrying away into the dark regions from which they spring those consuming pangs of homesickness which beset the student nurse as the holiday season approaches is a problem which is being skillfully met in many hospitals to the great benefit in morale of nurse and, indirectly, patient. There may be much of tragedy in the student nurse's first Christmas away from home unless active preventive measures are taken.

The element of mystery and surprise which is so large a part of Christmas in the home may be preserved with success in formulating plans for the nurses' holidays. It may simply be pancakes for Christmas breakfast prepared by no less a personage than the principal herself, decked in chef's cap and apron and with a fetching daub of flour on her nose, as a student nurse at Lakeside Hospital in Cleveland, Ohio, relates in her account of 1920 holiday festivities. Or it may be the bringing of unexpected happiness to others, as was accomplished by the "Brownies" from the Chicago Presbyterian Hospital in their distribution of baskets of "goodies" to some unfortunate families.

The exchange of inexpensive and ridiculous gifts on Christmas Eve around a tree made glittering and gorgeous by their own hands, the lifting of their voices in unison in age-old carols, a quiet story-telling hour around the fire on Christmas night after a bounteous dinner has been served and letters dispatched home, a week's program of children's parties, minstrel shows and tally-ho rides by moonlight are pertinent suggestions sent to THE MODERN HOSPITAL by student nurses themselves in an effort to assist their fellow students the country over in making Christmas time within hospital walls the joyous occasion it used to be when within the home circle.

Some of the girls themselves in the following paragraphs give vivid accounts of the pleasures in which they took part.—EDITOR.

FROM Mt. Sinai Hospital, in Cleveland, Ohio, Miss Eva Milton writes a graphic story of her first Christmas away from home and how it was made a merry one:

All Eyes on Bulletin Board

"This was to be my first Christmas away from home. Oh! wasn't there some way to arrange for my going home? That question was uppermost in my mind. So far during my probationary period I had been very happy and not at all homesick, but now, Christmas was

so near at hand—Christmas, the happiest and most eagerly anticipated holiday of the year, and I was not to be at home! Oh! I couldn't bear it. But, nevertheless, I went to work with grim determination and with the old fashioned thought that 'a nurse's life means sacrifice'—sacrifice of all merry-making, friends and in fact all that one normally enjoys.

"One day about a week before Christmas, as I hurried past the bulletin board on my way to lunch, I was attracted by a notice. Judging from the long list of nurses' signatures underneath, I thought it must be a petition for a Christmas vacation of a day or more. I was mistaken, however, for the notice read:

"WILL THE NURSES WHO WOULD LIKE TO CELEBRATE CHRISTMAS EVE AS WE DID LAST YEAR SIGN BELOW?"

"Last year"—yes—how well I remembered the Christmas Eve party at home! But Christmas here—I was doubtful. I reached for the pencil, however, added my name and proceeded to the dining room. Such chatter, everyone seemed to be talking at once. After listening for a while I learned that they were discussing the good time they had last year at Christmas. By the time luncheon was over I had quite forgotten about going home and was quite over my prejudice.

"What happy days followed! Everywhere the holiday spirit began to manifest itself. All faces registered contentment. Christmas parcels with the usual caution, 'Do not open until Christmas,' began to arrive. What delightful suspense! We probationers who were most likely to be homesick were asked to help with decorations. No attic, I'm sure, ever held more Christmas ornaments than ours brought forth and no trees could have been lovelier.

Back to Childhood Days

"Then came Christmas Eve. A 'children's' party was to be held in the recreation room. Much shortening of skirts and plaiting of braids took place in preparation for it. During the early part of the evening all the 'little' girls played games and danced. Later Santa Claus (one of the head nurses) was ushered in with his usual Christmas baggage. Every girl received a gift (several days before each one had drawn a name and purchased a twenty-five cent present for that person). Besides Santa's individual gifts there were other gifts for the nurses as a group. Several boxes of candy and magazine subscriptions were received from the staff doctors; from our own dear principal we received a col-

lection of Victrola records, including the latest song hits as well as classical music. The dietitian also had a surprise for us in the form of fruit, nuts and hard candies. The remainder of the evening was spent in dancing and singing. That evening as each little girl went reluctantly to her room I'm sure she felt that this was one of the happiest Christmas Eve parties she had ever attended.

"Five o'clock next morning—Christmas day. Our class had decided to awaken the faculty by singing Christmas carols. It was a delightful Christmas morning; the atmosphere seemed to have caught the spirit. Beaming faces and expressive 'Merry Christmas' were all about. As we sang we awakened the entire school and three-quarters of an hour later we had all assembled in the principal's office to make ready to sing to the patients. Formed in double file and carrying lighted candles, we marched through the wards singing all the old familiar Christmas carols. How impressive it was! Every nurse keenly enjoyed it. At 6:30 a. m. we went to the dining room, which had been decorated most fittingly, complete in every detail, even to the tree beautifully lighted with electric bulbs. The breakfast was a treat. Then after more singing of carols and school and class songs, a very happy group of nurses went on duty for half the day. At noon a bounteous dinner with all imaginable goodies was served.

"To complete our most enjoyable Christmas festivity, a formal Christmas dance was given a few evenings later by the school for the nurses and their friends, at the Masonic Temple nearby. This occasion, with elaborate decorations and an excellent orchestra, marked the climax.

"How ashamed I felt to think I should have doubted a happy Christmas! I feel sure that never before had an institution experienced a more delightful holiday spirit and more good will toward men."

Those in charge of the training school for nurses at Lakeside Hospital in Cleveland, Ohio, certainly believe that the Christmas holidays come around to be celebrated. Miss Evelyn Childs, a student nurse, tells of the holiday gaiety which pervaded those halls in the following:

Pancakes by New Chef

"Workaday Lakeside, pursuing her serious occupations, turns her holiday face to the world at Christmas time. No hospital students can play with more zest or work with greater zeal when duty hours demand than those at Lakeside. The happy spirit of fellowship and of service permeates the very air for several weeks before. The singing of Christmas hymns at the regular morning chapel helps to foster the spirit.

Nurses begin early to decorate the wards, and each head nurse tries to have her plans a surprise for her fellow workers, who tell little of the secrets enclosed in their cupboards. A general feature of each ward decoration is a large Christmas tree with its tinsel, candy, and popcorn festoons. Then, too, can be seen fireplaces with the time-honored stockings, while lanterns, wreaths and shades add to the colorful scheme. Nor is the nurses' home forgotten. The living room, class rooms, and halls each has a share in the festivities; in individual rooms quite original decorations are seen. In several rooms last year were small trees which were lighted on Christmas Eve.

"Another pleasure, begun several weeks before Christmas, is the carol practice, led by Mr. Kraft of Trinity Cathedral. Last year, Christmas morning dawned for us at 4:30 a. m. The nurses were awakened by a bell sounding on every floor, and hurriedly and happily they assembled to start on their round through every part of

the hospital to sing carols. The procession, headed by a nurse with small portable organ, was made more effective by the lighted candles. Two student nurses sang a duet. For once the patients made no complaint for having been awakened very, very early.

"On Christmas Eve we felt a secret was in store for us, but no one could guess its nature, however hard she tried. Upon returning from the hospital after the carols, a poster on the bulletin board led us by arrows to the surprise. The poster read: 'NEW COOK MAY BE EMPLOYED BY OFFERING HIGH WAGES. PANCAKES A SPECIALTY.' And whom should we find to be our new cook but our principal, Miss Allison, arrayed in a baker's cap and apron, baking pancakes for the student government council, which had been invited to have breakfast in the new kitchenette. The kitchenette was opened Christmas morning, fully equipped for the use of all the nurses. Pancakes for breakfast! It was a treat, indeed. They were enjoyed by all the nurses in their respective dining rooms.

Santa Visits the Children

"Soon the call for duty came, and the nurses assumed their morning work, happy in their patients' joy over the gifts which the Christmas trees bore for them. Later in the morning, as many nurses as could be spared from their floors went to see the Christmas tree on the Children's Ward. Santa Claus was there in person and he brought each child what he or she had wished for most. Happy was the day for the little patients!

"For the nurses who spent the day at the hospital, there was an especially good dinner, and in the evening a buffet luncheon was served in the living room of the nurses' home. To this the doctors and outside friends were invited, and it was followed by dancing. Finally the nurses and guests, seated in the living room, aglow from the grate fire, were surprised by Santa Claus, who arrived shaking the snow from his pack. The Christmas tree in the corner was laden with gifts, and these were distributed by Santa to each nurse, each gift being chosen as appropriate for the recipient, and usually not exceeding ten cents in cost.

"The following week was one of parties and gaiety. Each class selected an evening in which to entertain the rest of the students. Among these was a 'Last Day of School,' for which everyone dressed in her best, and 'spoke her piece' with pride but timidity. A minstrel show was successful, with its orchestra composed of members of the junior class. Other evenings were equally enjoyable, and the week ended with a pleasant memory on the part of the students, who, far from home, could wish for no happier holiday season than that at Lakeside at Christmas time."

Miss Gwyneath Porter was a student nurse at the Presbyterian Hospital in Chicago last year and she gives in the following words a touch of the holiday atmosphere as she felt it while on night duty:

Night Duty on Christmas Eve

"Who has not had a desire in childhood—if not in later years—to stay up all Christmas Eve and watch Santa come down the chimney, and see all the other things generally supposed to happen on that eventful night?

"I must confess that enough of my childish illusions remain to make the fulfilling of such a desire quite a delightful prospect. So it was with an inward feeling of 'something going to happen' that I went on duty at 11 o'clock that Christmas Eve. The air was crisp and cold and the blue-black sky, studded with twinkling stars, seemed to whisper peace and good will to the sleeping

city. In the wards all was dark, yet as I made the rounds I was aware of decorations and miniature Christmas trees which had been prepared during the day. A quiet night it was, for the patients slept well, so while I sat and made dressings I had time to think of the Christmases that had passed and of the joy that the Christmas season brought to the world.

"It was about three in the morning—just the time when sleep is nearest to getting the best of one on night duty,—when I went to the serving kitchen to heat some milk for a patient. Oh! how shall I describe the awful sinking feeling at what met my sight!—A beautiful sea green sink persistently overflowing itself onto the floor, which already lay covered an inch deep in water! Behold me, my sleepiness drowned in dismay, mopping as I have never mopped in my life before! And not till half the floor was dry, did I even think how funny I looked mopping so early on a Christmas morning. I 'phoned to the nurse's office in case some damage might be done to the floor below, and presently up came the night superintendent. Other nurses will appreciate the kindness of the remark she made, 'Never mind, it will be dried before daylight, and a nurse's training does not seem complete without some such experience.'

The Hospital Family Awakes

"Before I knew it, daylight was sifting in through the windows and doors, and I felt as I imagine many a mother does as I wakened my family and wished them a Merry Christmas, while they washed. Then across the court and up through the stairway came the voices of the day nurses as they sang Christmas carols from ward to ward.

"Excitement reigned, for were they all not going to have special diet orders for that one day calculated to include as many as possible of the items on the menus of the 'honest-to-goodness' Christmas dinner! Then there were letters and cards and boxes of candy and presence till bedside tables could hardly accommodate the array.

"Then home to breakfast. It is the custom in our school that there should be a special surprise planned by the housekeeper for that meal. This year it was in the form of rosy apples whose cores had been removed and in whose place grew fat red lighted candles. Sleep seemed well nigh impossible on such a day, but tired nerves must be pacified so a few short hours were spent in bed. Noon brought everyone together to a beautifully served and 'scrumptious' Christmas dinner.

Entertain in Sun Parlor

"An afternoon party was in progress in the sun-parlor on the roof at which some of the faculty entertained all the nurses remaining at home. Evening came, and to end up the day an entertainment had been planned 'for the family' to which the doctors and interns were also invited. A program of music and readings given by the nurses, followed by refreshments made the evening hours fly by.

"Eleven o'clock came all too soon and another night's work began, but such a lovely day will long be remembered as one of the happiest memories of my days in training."

Christmas for the student nurses at Blockley Hospital in Philadelphia must be a joyful season for Miss Ether Grimes' account of the holiday fairly radiates good cheer. She writes as follows:

"Such a hustle and bustle and stir! What is the matter with everyone! The nurses look so gay—and is this really a hospital?—everyone smiling and mysterious and

so jolly? To be sure, it's Christmas time! But don't the nurses wish they were home? Don't they miss their families? Yes—but—! Why the hospital is so Christmasy, that we forget to wish for home too much, just a little wistful longing now and then. The secret is this: That never before have we been given such a wonderful chance to make Christmas for others, and after all that is a real Christmas. We begin before Christmas even planning how our wards are going to look, all trimmed up in red and green and tinsel, because the hospital always lets us have those things, not to mention the fact that many interested outsiders give us things. Our own nurses' home and all the hospital wards are literally transformed and we feel as elegant and Christmasy as the display windows down on Market Street. Christmas night we go to bed knowing that Santa Claus knows just what each one of the youngsters wants, that the Christmas trees and the evergreens and the tinsels are making our patients forget for a while and helping them remember Christmas.

"About 4:30 a.m., the night nurses begin going around on tip-toe and look—well—kind of excited and expectant, and some of the patients, who just can't seem to sleep, wonder what is going to happen. Then is the time when the nurses feel a touch of homesickness and want someone from home. For the day nurses have risen about 4:30 and by 5 a.m. are walking through the hospital corridors, singing Christmas carols. There is a hushed silence everywhere as the music draws nearer and then gradually grows fainter. The nurses feel the sacredness of Christmas in those few minutes. Then another quiet time—daylight—breakfast—'Merry Christmas, nurse.'

Breakfast by Candlelight

"When the carolling is over, we have Christmas service in the little chapel. Then we all go to the dining room, but instead of entering as usual, we find the doors closed—this means another surprise. The doors are not opened until every nurse has assembled, faculty, graduates and students. The doors then open and we find fifty candle lighted tables, in the center of each slim blossoms of narcissi, the blossoms being the Christmas greetings to the students from the head nurses. We still feel the solemnity of the day, as we sing together a strong old Christmas carol. It is Christmas morning and we remember it is a holiday, so take time to enjoy the breakfast half hour, which is such an inspirational beginning for the day. Our dietitians also remember it is Christmas, and it is their efforts that make the Christmas breakfast a real Christmas feast. Best of all is the Christmas message which each one of us finds ready for us on the table. This special Christmas breakfast is one that we never forget.

"Then Christmas day begins. We go on the wards and feel as if we are in Toyland. For Santa has been there overnight, families have not forgotten it is Christmas, and if there are no families unknown friends play Santa Claus. Everyone is remembered. Of course there is work to be done, but it doesn't seem like work there is so much gaiety and friendliness mixed in. We all enjoy sending to the diet kitchen for our share of celery and cranberry to make the Christmas dinners look so appetizing.

"The morning goes too swiftly and we are again together in the dining room and almost feel that we are home. Such a dinner and we have a whole hour to enjoy it in! Of course we all have extra time off, but those of us who cannot go home, would almost rather not go off. It is such fun to play with toys, admire dolls, and talk about 'Christmas the first few years after Jim and I were married and the children were still youngsters.'

"Christmas day is over but not the Christmas spirit. We still have our party to which to look forward. This comes about the middle of Christmas week, and then is the time when the nurses and doctors play together and celebrate the Christmas holidays. The hospital is the host for the party and we are the guests. No time or trouble is spared in giving us a good time. The evening passes almost too quickly, as we mingle together, get acquainted or listen to Christmas music, sung by some of the nurses and doctors. We have a gorgeous Christmas tree, just glistening with tinsel and shiny decorations. Before we realize it, Santa arrives, and in his heavy pack is a remembrance for everyone there. Refreshments and dancing give an interesting and appropriate finish to this festivity.

"A week goes by—two weeks—Christmas time is a thing of the past, and then we begin to think of really writing home, thereby living over again our most wonderful Christmas—the Christmas that only Blockley can give us."

Miss Bess Everett, student nurse at the Chicago Presbyterian Hospital, writes of how she and her sister nurses found it is "more blessed to give than to receive."

"It was to be our first Christmas away from home and its contemplation was not a cheerful one. And yet, about two days beforehand we began to hear tales of other Christmases and to see signs of unusual preparation. The first indication was the arrival of a big Christmas tree on the morning of the twenty-third, and as it lay propped against the wall out in the corridor of the home, we promptly began to manufacture ideas of decorations and many of us sat up a wee bit later that evening stringing cranberries and popcorn—but the real draping and hanging of tinsel was for a later time.

"Right after lunch on the twenty-fourth, our house mother set out in the main corridor some fifteen or twenty market baskets filled with the makings of as many Christmas dinners, which she and several of the nurses who were off duty had prepared that morning. The food had been purchased from a fund collected from the student body and, if I remember correctly, there had been a 'stunt show' a few weeks before which had swelled the fund somewhat. To each basket was pinned a name and address of some 'deserving' family on the West Side which had been obtained through our

hospital social service department. It then became the 'Brownie's' as we colloquially call our brown-garbed probationers, privilege to distribute these baskets.

"By Christmas time, most of the new nurses had learned their way about the city, and very specific instructions as to cars and transfers were appended to each address. But even so it was somewhat of an adventure for us to actually get inside the homes in the tenement district. The recipients were most grateful and I remember how proudly one Bohemian mother took me aside to show me

a new flanelette red petticoat she had managed to purchase and make for her little Maria. Oh, they hardly let us go, they were so anxious to tell us of Christmases in the old country and how they were managing to almost make ends meet over here. Perhaps there was a tear or two but it all added to the poignancy of the season.

"Then we found ourselves near Hull House and so we snatched a little time to go through it and the Mary Crane Nursery to see their holiday preparations. How we all compared notes when we got home and were draping the fluffy, snowy popcorn ropes and brilliant cranberry garlands and the cherished tinsel of other years, from bough to bough of our tall spruce standing majestically in the big class room. The tree had been wired with many tiny electric lights and way up at the tip top was a 'Star of Bethlehem.' The tree was to grace the party, which is given yearly by the student nurses for the children in the neighborhood of the hospital, and those known to the social service department.

"We were so excited over the adventures of the afternoon and the prospects of the coming party that we scarcely ate our dinner. About 7:15 our guests began to arrive, fifty or sixty of them, and here and there a bright eyed, anxious

mother and a newly shaven, decidedly embarrassed head of a household. The tree was all lighted up and the rest of the lights in the room shaded with red and green crepe paper. Among the nurses we can always find a few who have taught school, kindergarten and playground, and they are the usual directors of the evening's games. We nurses, even some of the supervisors, joined in with the youngsters and played 'Drop the Handkerchief' and 'Hide the Thimble,' while in another corner some one told fairy stories and over at the piano quite

HOLIDAY SCHEDULE FOR NURSES*

Open House from Christmas Day to New Year's Day, inclusive. Hostesses appointed from the various classes to receive each afternoon and to preside at the tea table.

Christmas Eve: Christmas tree, Santa Claus, inexpensive mirth-provoking gifts for everyone and simple refreshments such as pop corn, candy, apples, nuts.

Christmas Morning: 4 a.m., Christmas carols in the hospital; 6 a.m., short Christmas service in the Nurses' Hall, which may be conducted by some visiting minister.

Christmas Noon: Christmas dinner with appropriate decorations, favors, and toasts.

Christmas Afternoon: A country hike for the nurses who have no friends in the city and do not care to intrude on their more formal acquaintances.

Christmas Evening: A homey get-together around the fireplace with someone to read the Christmas stories and myths; music and simple refreshments.

For the remainder of the week the various classes may be made responsible for one evening's entertainment, such as a moonlight trolley ride in a sight-seeing bus. This is usually not too expensive and is very refreshing and enjoyable. Or a second evening may be given over to a movie or theater party, according to the finances of the group. A third evening may be some home entertainment, such as card party, dancing, or minstrel show.

New Year's Eve: The last night of the holiday week is carnival night. Carnival night with everything that goes with it. Friends are invited in, music, dancing, etc.

This suggested program leaves three free nights for the students to make any outside engagements.

*This Christmas program for the student nurse is suggested by the nurses from the City Hospital in Cleveland, Ohio.

a group entertained itself singing everything from Christmas songs to the latest jazz.

Before we knew it in came Santa Claus (some one had commandeered the fattest jolliest intern from the hospital, and he surely did play his part well), and distributed to the kiddies little red net stockings that he took from the tree. Each boy and girl made his bow to Saint Nick and thanked him for the stocking. If he or she could be persuaded to sing a song or recite, we on the side lines applauded heartily and the fond mamma beamed on her blossoming offspring. The usual things were in the stockings—candy, nuts, fruit and a 'prize.' Then in came a tea cart, with loads of ice cream and cookies for every one. Ten o'clock arrived all too soon and we bid our sticky fingered guests goodnight.

Carol Through Corridors

"Such was our Christmas eve, and while we were having our good times, the patients over in the hospital across the way were being entertained in the fern- and holly-decked chapel on the fifth floor. For them was a more sedate Christmas program of music, stories, monologues, and on occasion we have had even a clever cartoonist among the patients who themselves help to entertain in conjunction with the 'platform talented' nurses and a few kind outside friends of the hospital who came to us often to while away for the shut-ins a weary hour.

"Five-thirty Christmas morning dawned, or rather it was not yet daylight as we all assembled on the first floor of the home, spick and span in the cleanest of uniforms, and proceeded over to the hospital, where we all finally got to the top floor, and following our leader and the violinist we marched two by two down the hospital corridors from floor to floor, past the wards, past the patients we knew and smiled an answer to their Merry Christmas—past opened doors, past the children's rooms, the interns' quarters, the half deserted offices, on down past the servants' quarters, everywhere singing Christmas carols. It was truly thrilling and we just couldn't decide whether we wanted to cry at the gripping about our hearts as even the sickest folks smiled and seemed to rest more easily, or to laugh aloud at Johnny as he jumped up and down in his crib frantically waving a new toy he had found next to his pillow.

"The morning's duty hours went like lightning and everybody was happy. Dinner, and such a meal! Everything from 'soup to nuts.' Those who weren't on duty during the afternoon hiked out to the park to skate or went to the theater or wrote home—I guess we all wrote home some time that day. And in the evening we wound up the two days' festivities with a party for ourselves where we danced and could bring our 'grown up' guests.

"Truly I shall never forget my first Christmas in training and am really looking forward to a repetition of all my training school Christmases again this year."

The class of 1922 joined efforts at the Illinois Training School in giving the following account of their jolly Christmas of a year ago:

Extra! Extra! Extra!

"Of all the happy memories, those clustering about Christmas, no matter where spent, are always closest to our hearts. Although it is the merriest, jolliest season of all the year, to those away from the home fireside for the first time, perhaps, it may easily become a sad, lonely experience. But to the student of the Illinois Training School, the memory of our last Christmas spent

here easily puts to flight the mere possibility of such an unhappy occurrence.

"First are the 'handbills.' Everybody likes a morning edition and here, throughout the holiday season, we have miniature newspapers edited by various groups, from which no one from faculty to probationer is excluded. These papers contain bits of news and gossip, a favorite or original poem, plenty of jokes, and amusing cartoons. Each number features some particular department of our training: the nursery, the operating rooms, the class room, etc. Every morning ambitious newsies, either go through the halls with their "extra" or take their stand at the door and sell them. Needless to say, these school papers find ready sale and contribute something to the atmosphere of cheerfulness.

"One of the wonderfully impressive customs of the Illinois Training School is the singing of Christmas carols early in the morning, while it is yet dark, by a group of students who pass through the corridors of the home and hospital, candles lighting their way.

"I sure thought it was the angels singin'," said one of the patients, awakened by carols echoing and re-echoing through the spacious halls.

"The children's wards, always interesting places, were never more so than at Christmas time. All spare moments were given to preparations behind closed doors, where stockings were filled, toys sorted and arrangements made for the big tree, not to mention Santa's costume. All this added to the air of mystery and expectancy in which the children lived during this wonderful week, producing many whispered confidences and a studied, almost angelic behavior, for they remembered the old admonition that 'if you aren't good, Santa won't bring you anything.' Bringing cheer to those in the hospital whose hearts might otherwise be sad is by no means the smallest factor contributing to the Christmas joy of the nurses.

"The Christmas party at the nurses' home was the biggest event of the week. Everyone was already prepared to enjoy this festivity because of the festal spirit which had found its way into all parts of the home. The hall, beautifully decorated with Christmas greens, the soft glow of dimmed lights, the holly sprigs above the fireplace, the always welcome postman with his heavy load of packages—who can forget these impressions? The party opened with a program consisting of several numbers, the originality of which could hardly be disputed. These amused the audience while awaiting the arrival of Santa Claus, due on the next reindeer express. With his appearance, the party became as jolly as one could wish. But it almost ended disastrously when shortly after his arrival, Santa Claus suddenly developed a severe pain which we, as expert diagnosticians, immediately pronounced acute appendicitis. Emergency measures were at once taken; the platform quickly transformed into an operating room. Santa was placed upon the table; ether administered with a soup ladle in lieu of a mask; the incision made; and such an anatomical disturbance was found! Numbers and numbers of foreign bodies were discovered and removed by an able surgeon. On examination these proved to be gifts for everyone. The operation was a success. Santa Claus lived. Then followed a success. Santa Claus lived. Then followed the distribution of gifts from the tree, refreshments, informal dancing and games. The evening passed only too quickly.

"Christmas itself, with all its gaiety and good times, was soon a thing of the past; but its memories remain, and, as said before, are very happy ones."

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Director, Dietary Department, Mt. Sinai Hospital, New York.

DIETITIAN'S PART IN SPREADING CHRISTMAS CHEER

TWO years ago several dietitians were asked to tell some of the methods they employed at Christmas time to bring cheer to patients, nurses, employees and others, forced to be away from home at this season which is so full of thoughts and memories of home and family. The request met with such an enthusiastic response and so many dietitians expressed gratitude for the suggestions contributed that the request was repeated this year. The majority of dietitians, it seems, consider Christmas a challenge not only to their best efforts and greatest skill in preparing a holiday feast but to their spirit of thoughtfulness as well. Not one letter received made any reference to the additional work or the numerous difficulties which a Christmas dinner implies. On the contrary, there were expressions from many indicating solicitude for the happiness of the patients and of their co-workers for whose Christmas dinners they were responsible. On the whole it would seem that the greatest joy of all hospital workers is found in doing for others, and, of course, no Christmas is complete without a dinner that savors in some way of a feast. Can you not feel the expectancy at Peter Bent Brigham as described by Miss Octavia Hall:

"Christmas day is always a day one wishes to be at home. In a hospital, everyone is away from home and so it becomes one of the greatest pleasures of Christmas to make them forget by bringing as much happiness and good cheer to them as possible.

"Of course the patients are the first and foremost consideration. The nurses always feel the Christmas spirit to such an extent that they themselves plan attractive little favors and decorations for their patients' trays. The hospital buys decorations such as wreaths and trees. There is a lovely, gaily trimmed Christmas tree in each

ward and many pretty wreaths at the windows and doors. Santa Claus comes around and wishes a merry Christmas to all and gives each patient some little present.

"Even after the visit of dear old Santa Claus, the patients still have an expectant look. Nurses hurry around more than usual and about twelve o'clock the most attractive trays begin to appear at the bedside of each patient. Some wards have pretty crepe paper baskets of nuts and raisins, and small red stockings full of

Christmas candies appear on the trays. The patients have the following menu served to them: Tomato bisque, celery, turkey, dressing, cranberry sauce, giblet gravy, mashed potato, cauliflower, tutti frutti ice cream, nuts and raisins.

"The nephritic and diabetic patients, of course, have weighed diets. In the diet kitchen has been written for all of the patients little place cards with a verse on each about the patient himself. This helps to take his mind off the fact that his neighbor is eating turkey or candy while he has none. But the diet kitchen has made everything as much like the regular house diet as possible and has introduced a tomato aspic salad in as many diets as will allow it. This helps to carry out the Christmas color.

"In one ward there are so many patients able to be out of bed that a table is set in the middle of the

ward. Nurses have brought decorations of crepe paper and have prepared an extremely attractive table for the patients to sit down to just as they would do at home.

"The nurses' dining room is decorated with holly wreaths and red bows at every window. Ropes of mountain laurel are festooned across the room. The centerpiece on each table is a flat holly wreath with little pine trees in the center. A few of the doctors have brought some pine trees, and little twigs are cut from these and

WHY KNOW PER CAPITA COSTS?*

In the past two years the writer has asked dozens of dietitians what their per capita cost is and not one in ten can tell. Some of these women have the reputation of being excellent dietitians though they apparently know nothing of the cost of running their department.

Dietitians in a large percentage of our hospitals are executives and usually they are members of the instructional staff. Do good executives in business ignore their cost accounts? Instructors in other phases of home economics know the exact cost of the course they are giving and usually the cost of each class group. Is the dietitian's work so different that it has no need of this knowledge?

Granted that she never buys anything she does not need and that she is too busy to do bookkeeping, can the dietitian give the best service to her institution by ignoring this item and giving her whole attention to other things? Or can she serve best by knowing the cost and letting it influence the management of her department?—

EDITOR.

*This is the second of a series of queries which will be a regular feature of the Department of Dietetics and Institutional Food Service for a number of months, depending on the interest which the questions arouse. Discussion is invited, with a view to summarizing and publishing in later issues of the magazine the opinions of dietitians, hospital superintendents and others.

put together so as to make miniature Christmas trees about eight inches high. These little trees are trimmed with bright tinsel.

"The doctors' dining room is trimmed in the same manner save for the fact that the very large round table is set for everyone and a Christmas tree with lighted candles burns cheerfully in the middle of the table when they come in. A bright fire burns also in the fireplace, a spot that had been considered a mere cavity in the wall and in which the tea wagon was wont to find shelter. The menu is: Oysters on half shell, celery, olives, radishes, turkey, dressing, gravy, cranberry sauce, candied sweet potatoes, creamed cauliflower, waldorf salad in red apple cups, wafers, tutti frutti ice cream, cake, demi-tasse, raisins, nuts, fruit and peppermint candy. Two turkeys, done to a golden brown, are brought in and two of the doctors carve them. 'May I ask you to pass the sweet potatoes, please?' is heard, and it seems like a big family dinner. When the coffee is served, the cigarettes lighted, the chairs pushed away from the table, and a good story started, it really begins to seem as if it were not so hard to be away from home on Christmas day after all."

At Massachusetts General Hospital also every patient able to sit up for even a short time had a place at the gaily decorated table. Miss Jessie Campbell tells us that this dinner is made more complete because a Christmas cake is provided by the head nurses. Special preparation is also made for the diabetics. They are given roast turkey, weighed to conform with their prescription; if possible the same vegetables are given to them that are served the others; salad of fresh tomato, lettuce, celery, and a dessert of agar jelly molded in fancy shape gives a festive appearance to the service. When permissible, forty per cent cream is weighed, whipped and served with the jelly. Cellu bran is also served (see recipes).

Napkins as Menu Cards

At Alameda County Hospital, California, native red berries are used on the trays. In the wards the menu is printed upon the napkin, and for private patients artistic cards are used to carry the menu. Fancy boxes with simple candies suitable for sick people are also on the tray. Miss Kerr says her menus are always made with a thought for everyone. There is fruit juice gelatin for the liquids and Spanish cream for the soft diets. Molded chicken consommé is a simple and delightful variation. Carrot pudding is substituted for plum pudding, made with butter instead of suet.

Miss Buckles, also, serves carrot pudding for which she has sent a recipe. Here, too, is her candle salad. A slice of pineapple is used for the base and one-third or one-half a banana placed upright in the center to represent a candle, topped off with a cherry or otherwise garnished.

Don't you like Miss Rinehart's, Pasadena, Cal., idea of serving a plate of fruit on Christmas morning? The plate contains a bright red apple, orange, raisins and nuts. It adds to the festive appearance of the room, and if the patient cannot eat it himself, he can offer it to his callers.

Miss Laura Bowles writes us from Sacramento that the Santa described by Miss Deaver in this department in 1919 afforded much pleasure to the patients and nurses as he stood on the tray with a real Christmas dinner. The graduate nurses in the hospital made the "Santas" and thereby shared in the fun.

Another example of helpfulness is shown at the Methodist Hospital in Omaha. The trays last year each had a hand painted card with the patient's name on it; these

were painted by a pupil nurse anxious to earn a little extra money. There were also individual candle sticks, one and a half inches high, holding a little red candle. These were placed on the tray and lighted just before it was taken to the patient. Wouldn't such a tray bring joy to any patient! However, Miss Ehler says the real "hit" was made by scalloped celery being served in individual pyrex dishes in which was placed a miniature Christmas tree. These trees were made from green paper cut and wrapped on a toothpick. Colored skewers could be used with similar effect.

In Louisville City Hospital, as in all city institutions, turkey or chicken is a rare treat to patients and almost equally rare for nurses, doctors, and employees. To quote Miss Howington, "the good news spreads through the city that the hospital will again put the little pot in the big one for Christmas and we are usually crowded for that day." Decorations and carol singing are supplemented by the beautiful old custom of burning a candle in the windows. The children's ward has a tree and Santa Claus provided by the social service department. The matron and dietitian make colored stockings and fill them with candy, fruit and a small toy; these are distributed Christmas morning by Dr. Tuley. Now comes the idea that I am sure is distinctly a Louisville City Hospital idea—A layette is provided for the first baby born on Christmas day on both the white and the colored obstetrical wards.

Party for Employees

Another unusual feature is the custom at Youngstown City Hospital, as told by Miss Winans. "The best Christmas treat for the employees with which I have helped was an absolute surprise to them. All the employees and their families living on the grounds were invited to the nurses' home from six to seven on Christmas Eve. They enjoyed the nurses' tree and decorations; a short program of songs and readings was followed by greetings from the superintendent. A treat which was given by the ladies' board was distributed, and they went happily away to their own celebration. When the nurses came off duty at seven they were all gone.

Since the training school at Mt. Sinai in New York is non-sectarian, the nurses have a very real holiday celebration. Money is contributed by the board of directors and interested friends which provides two pounds of good candy for each nurse in training and also provides a fund for purchasing books for their library and records for their victrola. There is always a tree and other decorations in the nurses' home. During the week a party is given at which is served homemade cake furnished by the supervisors.

A menu (No. 1) for an 150 bed hospital was sent us by Miss Joseph with the comment that she always considered the help and planned a menu on which much of the work could be done in advance so as not to interfere with half-days. The plum pudding was made just after Thanksgiving and the mince pie the day previous, and reheated. Trays are decorated and carols sung. A red ribbon tied around the glasses gave a bright touch to the tray.

Miss Proudfit is planning a health play for this year in which the nurses are to act. It is a fairy story dramatized for the children who are able to be taken to the nurses' recreation hall. For the older people, doctors, and nurses there will be enacted a series of scenes from the life of a nurse—and they will not all be solemn scenes either. Gaily trimmed bags of fruit will be distributed in the morning. The kiddies of this hospital are pleased

with a bright new five-cent piece placed in the toe of the stocking filled with candy. Carol singing is in the afternoon, so as not to interfere with hospital routine.

(1)

MENU (PATIENTS)

Clear Broth with Noodles		
Turkey		Dressing
Celery		Olives
Molded Cranberry Jelly		
Asparagus	Mashed Potatoes	
Ice Cream	Pound Cake	Christmas Cookies
Mints		Coffee

MENU (NURSES)

Noodle Soup		
Turkey	Oyster Dressing	
Cranberries	Olives	Celery
Mashed Potatoes	Baked Squash	
Plum Pudding	Hard Sauce	
Raisins	Salted Peanuts	Candy
	Coffee	

MENU (HELP)

Noodle Soup		
Turkey	Cranberry Jelly	Dressing
Mashed Potatoes		Squash
Mince Pie	Coffee	
Raisins	Peanuts	Candy

(2)

LOUISVILLE CITY HOSPITAL

(Doctors, Nurses and Employees)

Breakfast—Grapefruit, eggs, toast, coffee, cereal, jam.*Dinner*—Roast turkey, dressing, cranberry sauce, mashed potatoes, celery, buttered peas, coffee, plum pudding and sherry sauce.*Supper*—Hot coffee, bags containing fruit, candy, cakes and nuts furnished to all.

Regular Diet for Patients

Breakfast—Oranges, cereal, coffee, toast, hash.*Dinner*—Turkey, dressing, mashed potatoes, celery, cranberries, milk, chocolate pudding and sauce.*Supper*—Bags same as nurses, coffee and milk.

Modified Diet for Patients

Breakfast—Orange, coffee, cereal, toast.*Dinner*—Chicken soup, mashed potatoes, celery, milk, toast, chocolate pudding.

The following recipes include those referred to above and a few others:

AGAR JELLY

Agar jellies are made by adding one tablespoon of powdered agar to a pint of boiling water. When the agar is dissolved, pink vegetable coloring is added with saccharine and a synthetic fruit flavor to taste.

CELLU BRAN COOKIES

Cellu flour 25 gms., dry washed bran 60 gms., India gum 10 gms. Salt to taste. Cinnamon 1 teaspoonful, mineral oil, 6 tablespoonfuls, saccharine 1 grain, hot water 100 cc.

Mix dry ingredients thoroughly. Add oil flavor and hot water in which saccharine has been dissolved. Shape in very thin cookies and bake in hot oven until crisp and brown.

CARROT PUDDING (20 SERVINGS)

1½ c. grated carrots, 1 c. raisins, 1½ c. milk, 2 c. flour, 1 ts. cinnamon, ½ ts. cloves, ½ ts. allspice, 1 ts. soda, ½ ts. salt, 1 c. suet, 1 c. sugar, 1 ts. baking powder. Steam three hours. Serve with sauce.

CHERRY SPONGE (25 SERVINGS)

One cup each sugar and water. Add 1 qt. pitted cherries, simmer until soft. Press through colander. One-

half box gelatin dissolved in ½ pt. hot water in which pits have been stewed, add to fruit. When jelly-like, whip to froth then add beaten whites of 2 eggs. Mold. Decorate with cherries and whipped cream.

CRANBERRY ICE (100 SERVINGS)

Eight qts. cranberries, 4 qts. water, 4 qts. sugar, juice of 12 lemons (1½ c.). Cook cranberries in water. Force through a sieve, add 1-2 qts. water. Add sugar and lemon juice. Freeze to a mush.

PEPPERMINT ICE CREAM

One lb. peppermint stick candy, 2 qts. cream. Crush candy. Heat cream in double boiler, pour cream over candy, stir well, cool. Freeze.

ORANGE PUDDING (35-40 SERVINGS)

Thirty-four orange juice, 4 lemon juice, 4 c. sugar; mix. Add 16 egg yolks beaten and ¼ cup cornstarch. Cook in double boiler until it begins to thicken. Add 3 tb. gelatin soaked in ½ cup cold water. Dissolve in ½ cup boiling water. When mixture thickens, add 16 egg whites beaten stiff.

CREAM CHEESE

Mix cream cheese with chopped pecans. Mold two in brick. Cut in ½ in. slices. Serve a heart of beet on each slice.

ENDIVE AND TOMATO

Separate endive like celery stalks; lay in ice water half an hour and wipe dry. Peel some small tomatoes and cut into sections like oranges; put the endive on a cold dish with a little lettuce beneath it and arrange the tomatoes at the sides. Cover with French dressing.

BIRD'S NEST SALAD

Cut fine large tomatoes in halves and remove the inside. Make cottage cheese into small balls the size of marbles, and flavor with a little sage, rubbed through a sieve, and salt. Put three balls into each tomato half and arrange the tomato on crisp white lettuce leaves, or surround with the delicate leaves of watercress. Serve mayonnaise with this salad.

WHITE GRAPE SALAD

Cut white grapes in halves and remove seeds. Chop olives, not too fine. Make a gelatin solution in which a little lemon juice and sugar has been dissolved, not enough to flavor strongly. Add grapes and olives to solution. When it is solid cut in cubes and serve with mayonnaise.

CURRANT JELLY SAUCE

One cup currant jelly, separated with a fork but not beaten, 1 scant cup of finely chopped mint leaves, shavings from rind of two oranges, or grated rind. Mix carefully and serve with lamb or chicken.

SANDWICHES

One-half cup candied cherries, cut fine and flavored with two tablespoons of orange juice. Spread on crackers. This makes a very pretty and palatable sandwich.

Dates cooked, chopped and flavored with lemon juice make a delicious sandwich filling. Chopped peanuts are a desirable addition for some occasions.

RETURNS TO A. M. A. COUNCIL

The American Medical Association has recalled Mr. Homer S. Sanger to his former position with the council of medical education and hospitals. His work, in addition to hospital surveys and statistics, will be to assist in the assembling and publishing of information regarding dispensaries and clinics. Mr. Sanger will be remembered for his former work as superintendent of the Central Free Dispensary at Rush Medical College, Chicago.

FAVORABLE REPORTS FROM MIDDLE WEST

The editor of this department had the pleasure of visiting several hospitals in the Middle West during the past two months and found that these hospitals, along with the fifty or more which we had the privilege of visiting last summer, attach great importance to the dietary department. In every instance the medical men, as well as the superintendent, stated that they would never again try to run a hospital without a good dietitian. Is there any significance in the fact that six of the nine hospitals visited had women superintendents, including two Catholic hospitals?

In Council Bluffs, the Mercy Hospital recently engaged Elizabeth Powers to take charge of their diet kitchen and to teach the nurses dietetics. A room which at first seemed to offer a few possibilities, has been fitted up for a diet kitchen and through Miss Powers' ingenuity and a carpenter's skill, it has acquired conveniences, and many unique pieces of equipment which were originally made for much different purposes.

The medical men speak highly of the work of the department and say the patients are pleased. Can it be true? We recommend visitors in Council Bluffs to visit this hospital; they will find Sister Benedicta charming and cordial.

St. Joseph's Hospital in Omaha is another Catholic hospital having a dietitian, Miss Mabel Brown, who has been in this position for about three years. Here, too, a diet kitchen was equipped after the dietitian was secured, and Miss Brown has a very attractive, well lighted workshop. The doctors and dietitian are doing splendid teamwork and thereby getting very gratifying results.

At the Methodist Hospital in Omaha, Miss Ehlers has charge of the entire food service, and we pronounce it a splendid food service with emphasis on both the food and the service. Miss Ehlers has promised to tell us of her work so we shall not attempt it. A genuine family spirit prevails. This hospital sent the president of the board, the superintendent and the dietitian to the meeting of The American Hospital Association at West Baden.

At Peoria we found a newly equipped kitchen and diet room but no dietitian. This lack was due to the difficulty in finding dietitians at present, but Miss Serbray had succeeded in finding a prospective dietitian who is probably with her now.

The Home Economics Departments at Bradley Polytechnic Institute and Proctor Hospital are planning a course of training for dietitians next year which promises much.

Dietitians in New Locations

It is to be regretted that so many dietitians are having to give up work on account of ill health. Our last issue contained a report of several such instances and we continue to hear of others. It is gratifying, however, to know that a number have again taken up their duties.

Miss May Foley is back at Mayo Brothers Clinic, Rochester, Minn.; Miss Maud Perry has returned to Montreal General Hospital, though she has not quite regained her normal health; and Miss Martha Kimball has recovered sufficiently from a long illness to continue her work at Minneapolis General Hospital.

Other changes which have been made by dietitians are as follows: Edna Becker gave up her position at the University of Chicago to become Miss Little's assistant at Madison, Wis.; Miss Mary Merle Buckles is at the Memorial Hospital, Richmond, Va.; Esther Ackerson Fischer is no longer at the Chicago Beach Hotel, Chicago;

Dorothy Case has gone from Youngstown Hospital, Youngstown, Ohio, to a position in Detroit; Margaret Royal has accepted a position in the Children's Hospital, Detroit; Margaret Drew is with the Northern Pacific Beneficial Association in St. Paul (she was dietitian at the Northern Pacific Hospital at Brainerd, Minn.); Candace Easton is at her home in Monroeville, Ohio, since resigning from the U. S. P. H. S.; Anna Gehman is again at Griffin Hospital, Derby, Conn., after having been in other positions for two years; Zoe Harris has been chosen chief dietitian at the Missouri Baptist Sanitarium, St. Louis, Mo.; Josephine Holman is at Lawrence Memorial Hospital, New London, Conn.; Miss Lillian Karus, formerly at U. S. P. H. S. Hospital No. 30, Chicago, has been appointed chief dietitian of the Edward Hines, Jr. Hospital, Maywood, Ill.; Dorothy Olvey has accepted a position at the City and County Hospital, St. Paul, Minn.

We are concerned about the secretaries of the various city associations. We hope nothing serious has happened but there must be some reason for the lack of reported meetings. Not one report of local dietitians' association meetings has reached us. Surely there have been some October and November meetings.—EDITOR.

OHIO PLAN TAKES HOSPITAL FACILITIES TO THE CRIPPLED CHILD

In their efforts and achievements in taking hospital facilities to the crippled child, instead of bringing the crippled child to a central hospital, the Rotarians of the tenth district, organized as the Ohio Society for Crippled Children, are accomplishing a practice which they believe to be unique.

The Ohio plan, as fostered by members of the Rotary club in that district, reverse the old order of things in which crippled children of the state are brought to a single institution for remedial treatment and establishes in the state different districts, each equipped for handling the crippled child. The Ohio program when complete will provide ten or twelve working centers with total hospital facilities of from 500 to 1,000 beds. Nine are now in operation.

Rotarians in Ohio have set down for themselves the following goals in establishing centers for the care of the crippled child:

1. Hospital facilities of twenty or more beds in a thoroughly organized hospital, having a competent nursing force and proper equipment for all classes of work for crippled and deformed children.
2. The establishment of a weekly clinic for new cases and also old cases where the patient can return to have casts and braces adjusted, x-rays, and examinations.
3. An attending orthopedic surgeon with a consultant.
4. A survey of the entire district with complete records of all cases.
5. A system of follow-up work so that cases will have correct home treatment.
6. A school for the education of crippled children in the district and bedside teaching for children in hospitals.
7. Classes for slightly deformed children where corrective treatment may be given.

The Rotary Club in the tenth district was sponsor for the legislation which makes it possible for crippled children to be treated at state expense. Ohio is said to have 12,000 crippled children. One thousand of these have already received treatment at the Gates Hospital in Elyria.

The public safety is the supreme law.—Bacon.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

HOW TO SERVE FOOD "PIPING HOT" TO THE PATIENT

THE tastiness of cooked food and, in some instances, its nutritional value, depends to a marked degree upon the temperature at which it is served. To serve foods "piping hot" has always been a problem. Even in the home, where the task largely resolves itself into the proper timing of cooking operations, it has been considered the measure of a good cook to be able to serve all dishes at the proper temperature.

The ideal and, likewise, the most simple method of insuring hot food service is direct from the range to the individual. This was the original order in public eating places, and even today is followed on "short orders." As conditions became more complex, as eating places became larger and meals were served for a longer period of time, a different kitchen routine was established. This is particularly true in those restaurants and eating places where established menus are served.

To meet these new conditions, the modern steam table was designed, in which cooked food is kept at a constant temperature by means of a water jacket or water pan, which, in turn, is heated by gas or steam. This method has been the accepted installation in restaurants, cafés, hotels and, until of late, the majority of hospitals. There is no question but that the steam table of today serves the purpose of keeping the food hot. It cannot, however, be said that steam tables maintain the palatability of food or that food does not suffer to some degree by being kept at a semi-cooking temperature.

With the development of the modern hospital, food service has become a far more complicated problem, until it is conceded that the steam table as used in the general kitchen is not an aid, but rather a detriment, to efficient food service. This statement naturally does not apply to every institution. To those hospitals which are able to serve all patients direct from the central kitchen, where possibly the food service devolves upon a limited number, thus lengthening the time of the meal, the steam table is still an essential. In the larger modern institutions,

however, the use of a steam table, according to present kitchen routine, means but an additional handling of the food without added benefit.

This change in hospital food service is due to several factors. The increase in size of institutions made it increasingly difficult to serve all from one central kitchen. The change in hospital design was another factor. The pavilion, cottage and wing type of construction demanded different methods in food service. Ward kitchens or at least serving rooms were installed. The increase in the number of private rooms called for a further modification in methods of serving food, while the advance in dietetics with the resultant special diets added another complication.

The modern routine of food service calls for the food to be prepared in a central kitchen or kitchens, served direct from the range to various containers, and then transported to the outlying cottages, buildings, various wards or floors for service at the bedside or from special serving rooms or diet kitchens. This change brought

into existence a wide range of food service containers and carriages to meet different conditions. There is a total lack of standardization in such equipment. In fact, it does not seem possible to effect approved or standardized equipment, because of the wide variety of conditions existing in various hospitals. Therefore, no attempt is made in this article to recommend any particular type of equipment, but rather to present illustrations and descriptions of various types of equipment from which the hospital executive will be able to select and adopt the type or types

most nearly meeting the special requirements of his institution. The use of the illustration must not be construed as a recommendation of the product of a particular factory but as presenting an example of general design.

No attempt will be made to illustrate or describe the simpler forms of food containers or carriages, which are merely vehicles of transportation and do not attempt to provide means of retaining or furnishing heat while the



Figure 1.



Figure 2.



Figure 3.

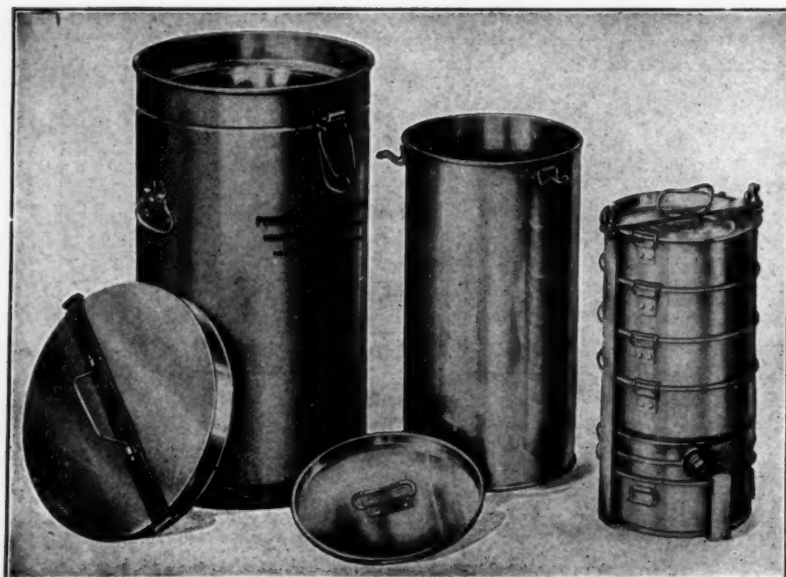


Figure 4.

food is being transported. There is a wide variety of such equipment which is undoubtedly valuable in simple installations where difficulty in keeping the food hot is not a problem.

In studying the equipment described, it is at once apparent that there are two general divisions. The first, by means of insulation, aims to retain the original heat of the food. The second class does not depend entirely upon insulation, but provides means of adding heat to the food and thus maintaining proper temperature for serving.

The simplest form of insulated food containers is the so-called vacuum bottle. These containers are made of either glass or metal with a double wall in which a vacuum has been created, this vacuum insulation successfully maintaining temperature for a considerable period. Although intended primarily for the storage or serving of liquids, certain forms of these containers are also suitable for more solid foods. Owing to the fact that the original temperature can be maintained for long periods, vacuum containers are more useful for the storage of foods than merely for transportation and service.

Figure 1 represents a common type of the vacuum bottle, the wide mouth allowing solid and semi-solid foods to be served.

Figure 2 is a vacuum carafe which is particularly suitable for room service.

Figure 3 is a vacuum pot which is made in different sizes and designs and which is highly desirable for the service of hot beverages, broths, soups, etc.

All of these containers are made in a variety of styles and finishes, and while excellent for keeping foods hot, can also be used in the storage of cold beverages and foods.

It is a natural step from considering the small vacuum containers of limited capacity to study the large size containers in which the same principle is employed. In these cases a vacuum container of metal is furnished in which a number of separate utensils can be fitted, permitting the transportation of these containers a considerable distance without appreciable loss of heat even after many hours. Such vacuum containers are made in various sizes, holding a number of individual containers, these being, as a rule, made of aluminum with tight fitting lids. The adaptability of such service to larger institutions with outlying cottages or pavilions is self-evident. The food can be either cooked in the small containers or served direct from the range after which the containers are stacked in the vacuum insulated holder and are then ready for carrying a very considerable distance.

A similar outfit is now being made in a large range of sizes in which the outside container is insulated by a special insulating material instead of by the vacuum walls described above. This outfit is shown in figure 4, and this illustration, while specifically showing the specially insulated container, is similar in appearance and design to the vacuum container described in the preceding paragraph. The outfit is furnished with a single large interior container, if desired, or with a number of small interior containers which may be stacked for convenient heating. In fact, almost any modification in the size of the outfit or of the interior containers can be secured in order to meet

the special requirements of various institutions.

There has been recently designed a special device par-



Figure 5.



Figure 6.

ticularly adaptable for food service in private rooms or small wards (figure 5). While relying on the exterior container for the retention of heat, provision is also made for heating special asbestos pads which add to the heat retaining qualities of the outfit. This device has been used with considerable success by a Chicago hospital where special electric cabinets have been installed as a convenient method of heating the asbestos pads. The outfit consists of a fiber exterior container. The food is placed on various shelves of the rack and then the entire set is placed in the carrying container. Specially prepared asbestos pads which have been heated fit into the removable cover, keeping the food and dishes warm, provided service is fairly prompt. This device is suitable only for limited service, as the entire outfit weighs but eight pounds, is twenty-four inches in height and twelve by fourteen inches in width and depth.

The equipment thus far described does not offer means of ready transportation. Special utility trucks or wagons must be employed. In the average hospital, however, it has been found more convenient to have food service carts mounted on wheels or casters, permitting immediate and

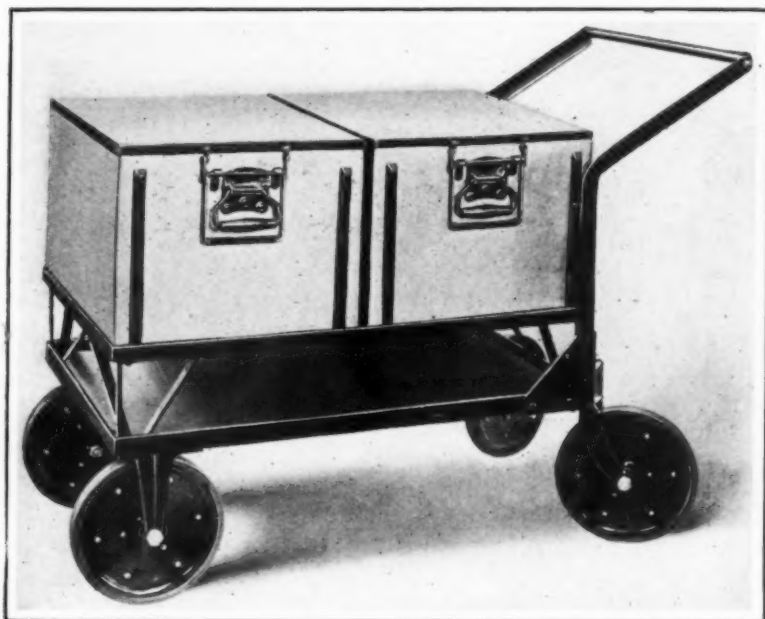


Figure 8.



Figure 8a

ready transportation to other buildings, floors or the various wards.

There is a wide range of such food carriages with different arrangement of shelves and doors, each representing the ideas of certain hospitals.

The food carriage shown (figure 6) perhaps represents the more approved type. Sliding doors have the advantage in that they do not



Figure 7.

produce the vacuum or pressure that is frequently present in opening and closing hinged doors. The various compartments of this wagon are absolutely separate, being divided with double steel walls, lined with asbestos. The entire compartment is made with double walls on the back, sides, top and bottom, lined with asbestos, retaining heat to a large degree. Various sections are divided by uprights walls so that the tight fitting sliding doors close each separate space, preventing the other compartments from cooling. A further feature of the particular wagon shown the rubber corners which prevent injury to

hospital walls. Food can be carried in this wagon in the original containers or in special aluminum containers with inset covers, such as are used in fireless cookers. It is claimed that the design of the running gear in this particular wagon has many advantages over ordinary four wheel construction, as the weight is carried to a large degree on the larger wheels.

The more direct application of insulating material has resulted in several different types of food carts which are constructed on the fireless cooker principle in which the food containers are completely and closely surrounded by specially prepared insulating material. This method permits the food to be cooked in these special containers and then placed directly in the cart, or else served from larger utensils and then transported to the ward. Service in the ward may be made direct from the container at the bedside or, if desired, in the special serving room or diet kitchen. It is customary in the fireless cooker type of food carriage to have separate units each con-



Figure 9.

aining four or six food containers. These units can be removed from the truck and sent from or returned to the kitchen by elevator or dumb waiter.

Figure 7 shows one of the smaller types of food carts,

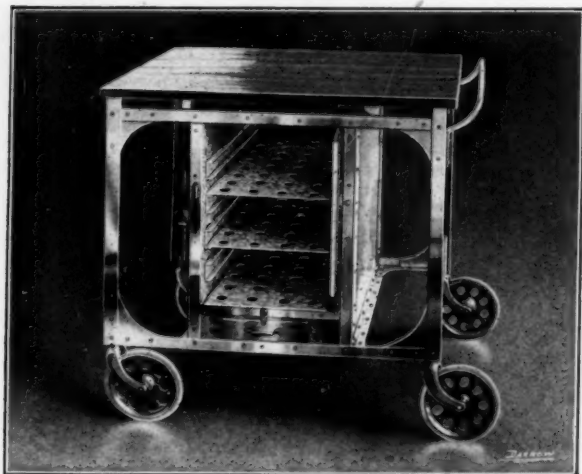


Figure 10.

this particular cart having a capacity for a four dish meal for from 25 to 40 patients.

Figure 8 is a larger outfit of similar design, except the insulation does not surround the food containers but is limited to the exterior walls. The illustration shows two separate units each containing food utensils. In this particular design the units are set on a removable platform so as to elevate them to more nearly table height and to provide a shelf for dishes, trays, etc.

There are many advantages in the fireless cooker type. No heating element is involved and the operation of such service requires but little attention, while the heat of the food is retained to a very high degree.

A modification of the fireless cooker idea is shown in figure 8a and provides all necessary facilities for hot food service at the bedside. The outfit includes in addition to the in-

sulated food containers shown at the top, various shelves for carrying dishes, cutlery, glassware, etc., and provide in this way what is practically a complete unit. The insulated containers or fireless cookers contain a large aluminum receptacle in one, two receptacles in another, while the third contains three aluminum receptacles, thus providing storage for a six dish meal.

One of the simplest forms of food cart is shown in figure 9. It consists solely of the carriage of more or less regulation pattern, which is provided with four or more copper boxes provided to suit. The food is placed in these boxes in bulk and then sent to the diet kitchen where it is either served direct or reheated. This type of cart depends solely upon the containers to retain the original heat of the food.

When dependence is not placed upon insulation for retaining heat, it is necessary to provide heat in some other manner. This has been done in a variety of ways, all of which have their advantages and, likewise in many cases, very distinct disadvantages.

Figure 10 shows a combination food cart and serving table. The cabinet in the center is made with double

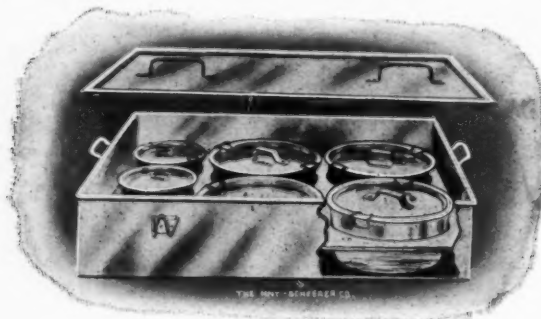


Figure 11.

walls, insulated with mineral wool. A specially prepared composition bricklet is supplied which is supposed to be an odorless heating element. The top is of polished

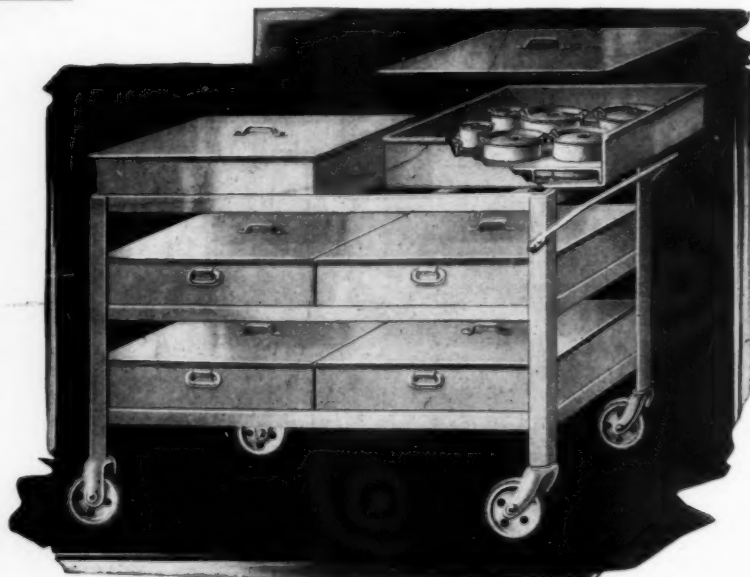


Figure 12.

mahogany and may be used for serving a meal to convalescent patients or as a bedside tray. This outfit is not designed for wholesale feeding, but is better suited for private rooms or small wards. It undoubtedly has considerable value in a limited number of institutions, particularly of the sanatorium type.

One of the common methods of maintaining heat is by means of a hot water jacket. There are a number of such food carts sold, some depending solely upon the hot water, while others provide a special heating stone, placed in or under hot water tray. An electrical connection which can be made after the cart is brought into the ward or serving kitchen is a feature of some models.

Figure 11 shows a typical food tray with aluminum insets and hot water base. These are, as a rule, made in units to insure easy handling.

In many government institutions a simple form of food cart containing such trays is employed. This is well illustrated in figure 12. It is a simple skeleton truck made to hold six food boxes, each containing aluminum containers and hot water base.

A smaller and simple design of food cart with hot water heat is shown in figure 13. The lower compartment provides storage space for dishes, trays, etc.; the upper part contains food receptacles with covers. These are kept warm by hot water, provision being made at the side for drawing off the water upon its return to the kitchen.

Figure 14 is more elaborately designed, having seven food receptacles in the rectangular container and a meat tray with a telescopic cover.

In the one end of the lower cabinet a compartment is provided for hot coffee, with an independent heater. The

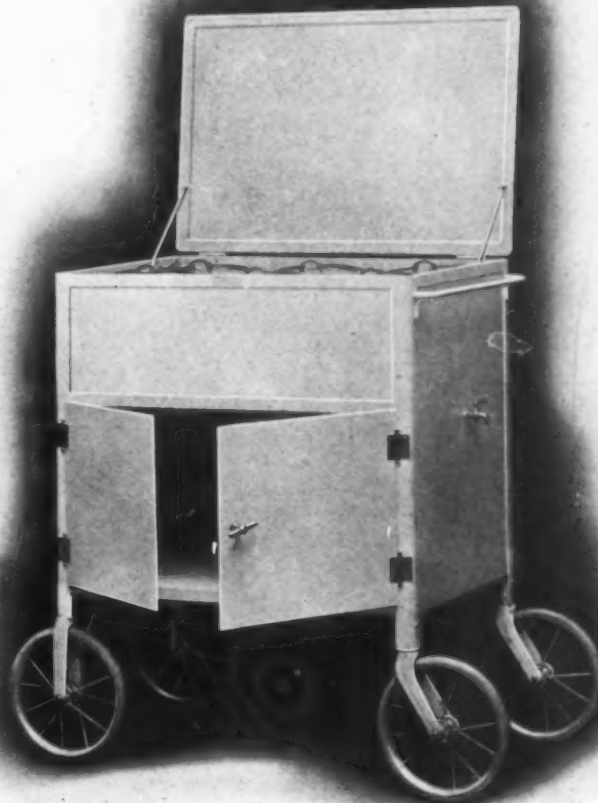


Figure 13.

with provision for heating stones, is utilized for retaining the heat. This cart also provides other conveniences, including a cupboard with three shelves at the top for



Figure 14.

rest of the lower compartment is provided with shelves for dishes and trays. *The outfit is designed for hot water base with further provision for soapstone blocks.

Figure 15 is a compact, convenient type of food cart with a rectangular copper container having a meat box and several aluminum receptacles. A hot water base,

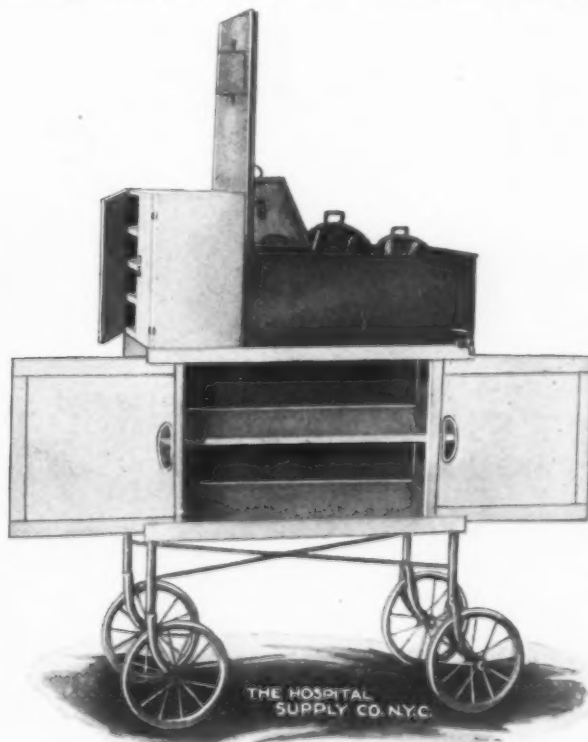


Figure 15.

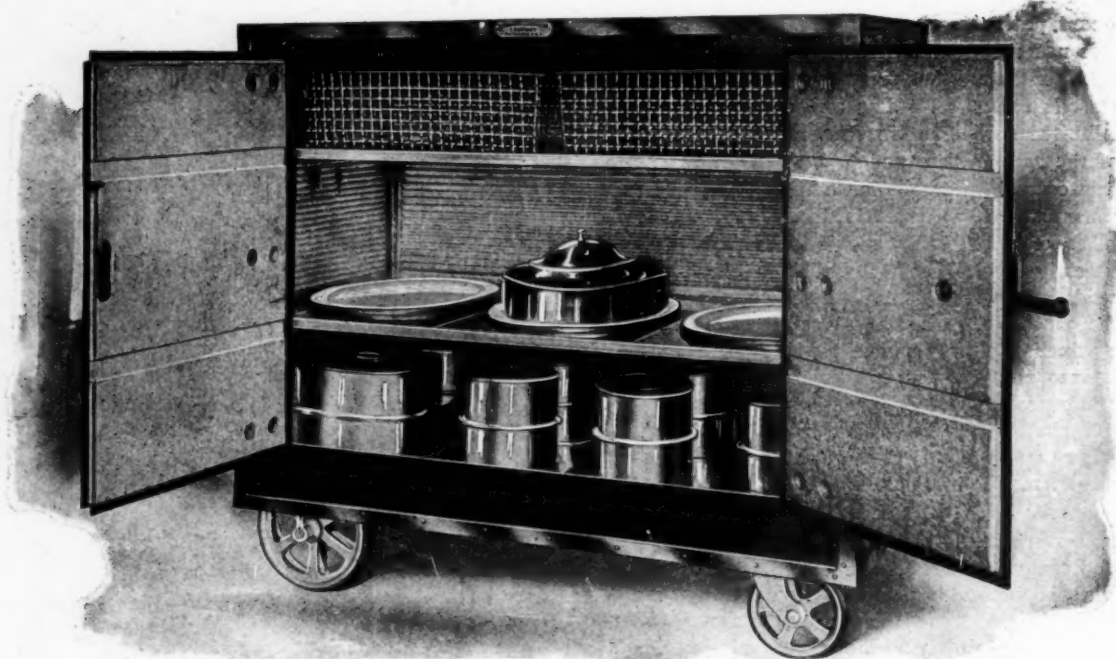


Figure 16.

holding bread and similar food, and a compartment with sliding doors below for dishes and other utensils. While this cart is primarily designed for hot water heat, it also permits of the installation of electric heating devices.

Larger institutions will be particularly interested in the complete food cart shown in figure 16. The cabinet proper is made of a double wall construction, thoroughly insulated. The upper part contains retinned wire baskets for holding dishes. In the center shelf are large platters with covers for meats, while the lower shelf contains va-

rious size aluminum utensils for other foods. This particular wagon depends upon its insulation for maintaining the heat but it can be provided with hot water base equipped with steam coils or gas burners, or with electric heating units.

Figure 17 is essentially a steam table truck. The base is provided either with open shelves as shown or with sliding doors if so specified. The truck is originally designed for hot water heating, supplemented with steam connection or gas burners, but electric heating units can

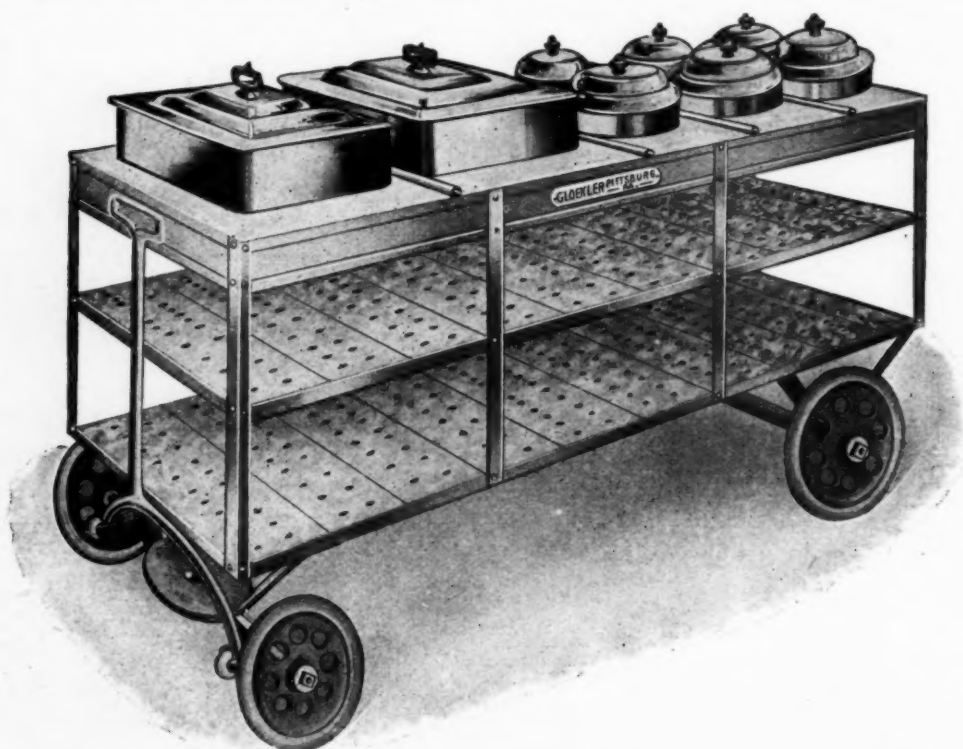


Figure 17.

also be supplied. The illustration clearly shows the arrangement of the top which conforms quite closely with customary steam table arrangement.

While it is possible to use these portable steam tables in wards for bedside service, their size and completeness better adapts them for use in the serving room or diet kitchen where connection can be readily made for steam, gas or electric heating.

Figure 18, however, is well suited for bedside service in wards. This is the steam table type utilizing hot water for heating, supplemented by a condensed fuel which is supported on two removable trays beneath the water. The adjustable shelf at one end is convenient in serving, and the lower compartment with sliding doors provides ample storage space for necessary dishes. The arrangement of the top follows the usual custom with meat tray with telescopic cover, and four aluminum food receptacles.

Electricity is gaining favor as a means of heating portable steam tables or food carts.

Figure 19 shows a large capacity food cart, provided



Figure 18.

Another type of electrically heated food carriage figure 21. is designed primarily for bedside service. The small upper compartment with drop door contains two three and three six-quart insets, together with a covered meat platter. The top is Monel metal, as is the sliding shelf. A convenient compartment with doors and shelves gives facilities for storing dishes and trays.

Probably the most complete type of portable food service is a recently designed service wagon (figure 22) equipped with electric heating units. This is essentially a heavy duty outfit, strongly constructed and completely equipped. The top section contains two large meat platters with telescoping cover and two vegetable containers, also equipped with telescoping cover, the latter divided into two compartments each, thus providing space for four different foods. These containers, and also the plate warming closet in the base, are heated by electricity; an upper shelf adds considerable convenience in service. The top of this cart is made of either Monel metal or heavy steel covered with nickel silver.



Figure 19.

with electric heating units. The cart itself is divided into compartments with five shelves. The heating element is at the bottom. It is suggested with an outfit of this kind to heat the truck thoroughly by attaching the heating units while in the kitchen, and then again to attach it to a lamp socket while the food is being served in the ward. This cart is designed solely for transportation purposes.

A convenient type of portable electric steam table is shown in figure 20. The top, of nickel silver, is equipped with an aluminum coffee urn, two meat pans with covers and four aluminum vegetable containers with gravy pan. This carriage is provided with hot water base with electric heating units in addition, and while designed for bedside service, is equally suitable for serving room use.

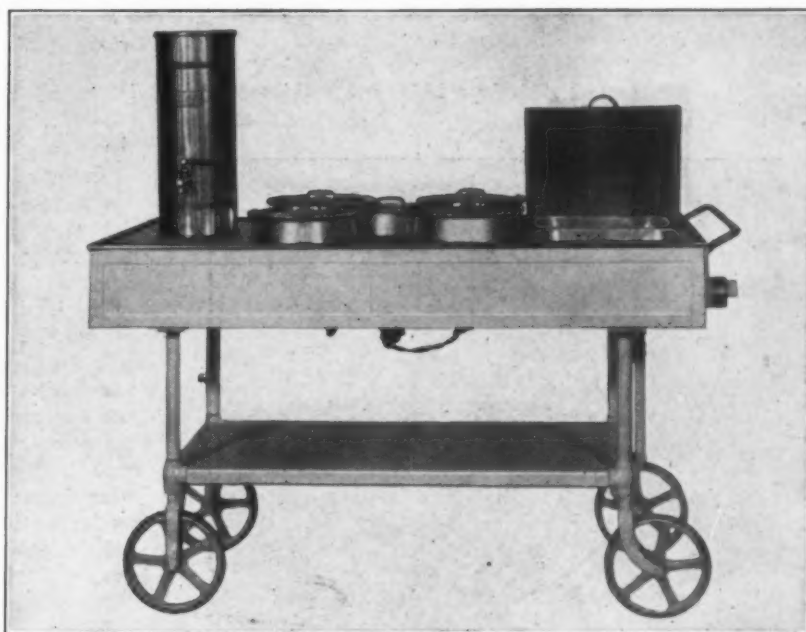


Figure 20.

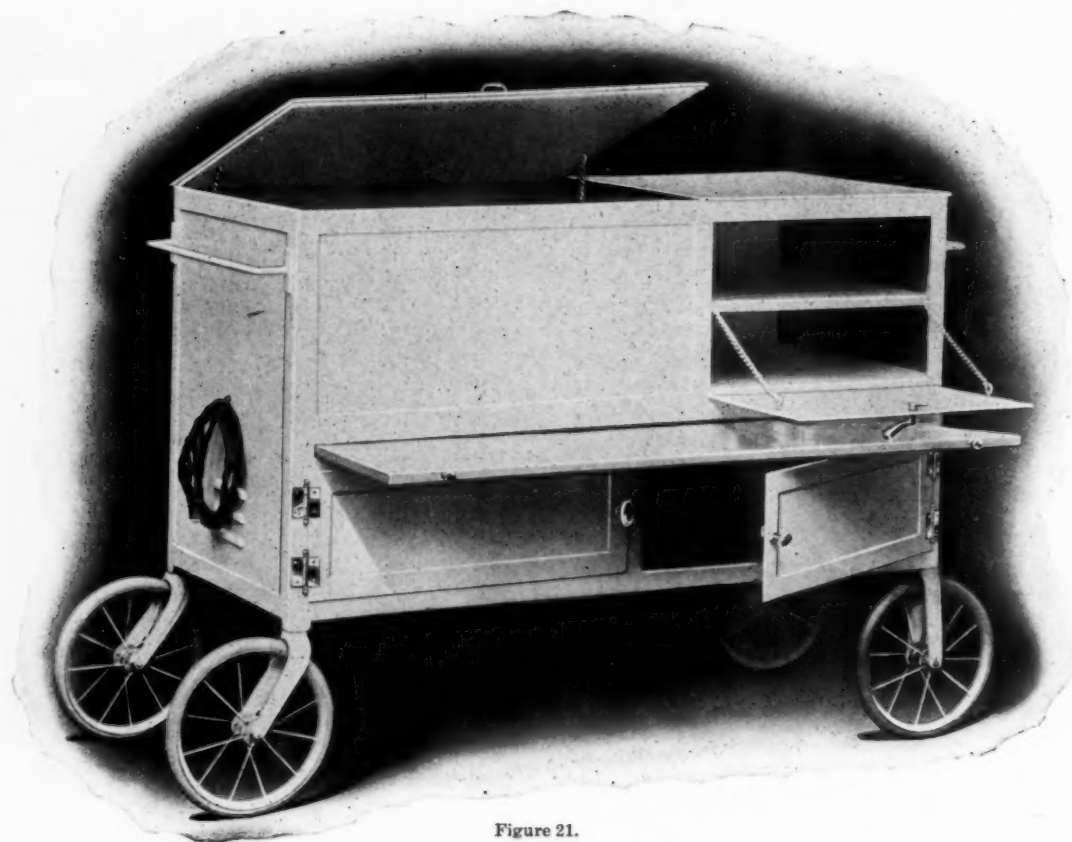


Figure 21.

As stated earlier in this article, it is impossible to attempt any standardization of food carriages or recommend any particular type for general use. There are certain outstanding facts which must be considered in the selection of equipment and these facts have to do primarily with the planned serving routine of each institution.

Where the hospital consists of outlying pavilions or cottages, provision should be made for very heavily insulated food containers, so that the heat can be largely retained. Such equipment can be arranged either for bedside service or merely for the transfer of the food to serving rooms.

In hospitals located entirely within one building, food service resolves itself into three general classifications.

Where bedside service is attempted, food carts should be selected that provide not only methods of heat retention, but also facilities for such service. A system of this kind would require a sufficient number of these carts so as to serve amply the entire institution and these would be centralized in the main kitchen and loaded direct from the range.

In some institutions tray service is used almost entirely with trays made up in the main kitchen. In such instances food carriages with insulated walls and preferably with hot water or some other heating element should be secured so that the trays may be loaded on shelves and distributed with a minimum loss of heat. According to such a routine, food carriages again would be centralized in the kitchen and the trays made up either from a range or from a special serving table. Such service would probably require a steam table in the central kitchen.

In many institutions service is handled from ward kitchens or serving rooms. To meet the requirements of such service, a food carriage designed like a steam table or service table should be installed. This should be equipped with connections for heating by either steam, gas or electricity. This suggested routine would call again for the centralization of these portable steam tables (so-called) in the kitchen where they would be filled direct from the range and then transported to the various serving rooms where connections of heating units would be made.

Conditions vary to such an extent, however, that in few institutions will one of the above suggestions be entirely adaptable, but will call for modifications or combination of the above suggested routine.

It might be added that additional provision, which would perhaps contemplate a small stationary steam table, must be provided for the service of the dining rooms for the staff and nurses.

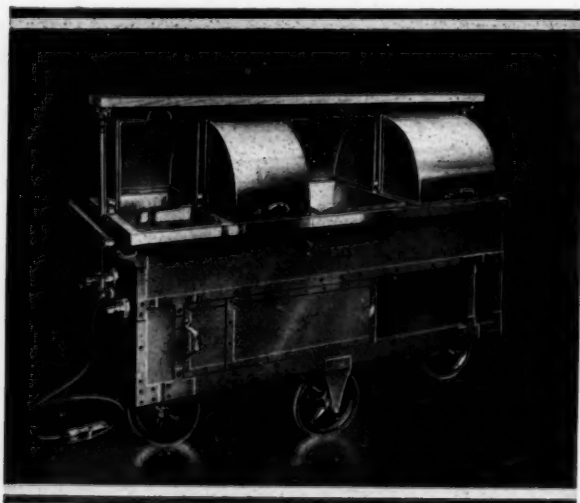


Figure 22.

LINOLEUM AND CORK CARPET IN THE HOSPITAL

NEW and improved methods of installation, together with recent improvements in manufacture, have demonstrated the desirability of linoleum as a flooring for use in many sections of the hospital. There are several general kinds or classes of linoleum peculiarly adapted to hospital floors. These are battleship linoleum, inlaid linoleum, linoleum tile and cork carpet.

All types of linoleum, speaking in a general sense, are manufactured in about the same manner and from the same raw materials. Cork is ground to a very fine powder, then thoroughly mixed with a linseed oil binder made up of oxidized linseed oil, rosin and imported gums. The necessary coloring pigments are then added. The composition, after it has been mixed, is pressed firmly upon a strong burlap base by heavy steel rolls or hydraulic presses. Inlaid linoleum as a rule contains wood flour instead of ground cork or in combination with ground cork.

Drying and seasoning of linoleum is an important step. It takes from ten days to two months, according to the thickness of the linoleum. The temperature of the drying rooms often is as high as 160° F.

Best Brands of Linoleum

The best brands of linoleum are those in which the mixing of raw materials has been thoroughly done, and seasoning has not been hurried. Thorough and repeated mixing insures a solid, firm piece of linoleum with a smooth surface. Slow, careful seasoning removes the danger of the linoleum being hard and brittle on the surface, and soft, mushy and moist in the center. If it has been evenly and carefully seasoned throughout, its life will be noticeably longer.

The hospital architect, superintendent, and building committee will naturally be interested mainly in battleship linoleum. Most of this flooring is manufactured in a dark brown color which has proved itself the most satisfactory under ordinary conditions. It blends well with any color scheme and can always be closely matched if additional quantities are needed. A third reason for the great popularity of brown linoleum is that it shows footprints to a minimum extent. It always looks attractive and clean.

Battleship Linoleum

This is a linoleum of very fine grade, noted particularly for its strength and durability. The name "battleship linoleum" does not apply to the product of any one manufacturer; it applies to a quality standard and implies that the linoleum meets the rigid specifications set by the U. S. Navy for linoleum which will withstand the terrific wear given the decks of battleships. Battleship linoleum (manufactured in several thicknesses and colors) has been found to be the most satisfactory for flooring in wards and corridors. It is easily cleaned and cared for, especially when the standard dark brown color is used. It possesses comfortable resiliency and springiness under foot and has sound-deadening qualities which are particularly valuable. Considering the fact that the thicker grades make a permanent floor, the cost is small, considerably less than hard wood, mastic or composition floorings. Many of the foremost hospital architects specify battleship linoleum throughout the hospital building, offices, dining rooms, private rooms and nurses' quarters, as well as wards and corridors.

In selecting linoleum floors, it is necessary to become

familiar with the different thicknesses manufactured. Battleship linoleum is made in three grades: one-quarter inch, three-sixteenths inch, and one-eighth inch. These grades or thicknesses are ordinarily termed heavy, medium and light battleship respectively.

Often, however, a grade known as "six millimeter" or "commercial heavy" is to be found on the market. This grade is somewhat under one-quarter of an inch thick. Unscrupulous contractors have been known to furnish it when the specification definitely called for the genuine quarter-inch or heavy battleship linoleum which meets the rigid Navy specification, thus fraudulently increasing their profit out of the owner's pockets.

How to Tell Linoleum Quality

There is one sure way to guard against inferior linoleum being substituted. The United States Navy Department, large users of heavy linoleum for the decks of battleships, has drawn up a set of rigid specifications. See that your linoleum agrees with these navy specifications. This will frustrate any attempt to substitute inferior material. Specifications or orders for battleship linoleum floors should include this clause: "Linoleum to be full one-quarter inch, three-sixteenths of an inch, or one-eighth of an inch in thickness, according to specifications 29LIC, U. S. Navy Department, September, 1916, and shall in all other respects conform to these specifications."

The contractor should be required to furnish two samples of the linoleum to be installed; one of which should be retained for comparison with material actually delivered.

Inlaid Linoleum

In deciding upon floors for the many small and medium-sized rooms in the average hospital, due consideration should be given to inlaid linoleum and cork carpet. Inlaid linoleum makes a patterned floor, and there is an almost unlimited number of designs from which selection can be made. As the name implies, the design or pattern of this kind of linoleum is built through the entire thickness of the goods, and cannot be worn off. There are several thicknesses, ranging up to the heaviest type, which is approximately one-eighth of an inch from face to back. Although comparatively little inlaid linoleum has been used in hospitals in the past, it is well suited for small dining rooms and offices.

Printed Floor-Coverings

On the market are some patterns of printed linoleum and felt base floor-covering which are almost identical in appearance with those found in inlaid linoleum. In this kind of floor-covering the pattern is merely printed on the base and will wear off in a comparatively short time. Though these printed goods may be suitable for home or store use they will not stand the gaff of hospital use. Care must be taken that this cheaper and less durable product is not erroneously bought in place of real inlaid linoleum.

Cork Carpet for Extra Quiet

Where quietness is the main consideration, cork carpet has much to recommend it, for it is softer and even more resilient to the tread than the other linoleum products. These qualities are obtained by using a coarser grade of ground cork and by a different treatment of the linseed oil.

Most cork carpet (which comes in several different colors), is made about one-quarter of an inch thick. Lesser thicknesses may be obtained, but when made much less than one-quarter of an inch in thickness, the main characteristics, quietness and resiliency, are partially lost. Cork carpet, on account of its porous surface, cannot be cleaned quite so readily as battleship and inlaid linoleum, and its use, therefore, should be confined to floors likely to have a rather light traffic, and where absolute quietness is essential.

The resiliency and "give" of cork carpet cannot be found in any other of the floorings suitable for hospital use. It is, in fact, a specialized product. For quiet zones it is superior to battleship, inlaid and tile linoleum.

Linoleum Tile

Yet another type of linoleum floor is the floor of linoleum tile. Though comparatively expensive, this makes a good floor for waiting and reception rooms, passenger elevators, and other public rooms of similar nature. This floor resembles inlaid linoleum in its general effect. It is however, about twice the thickness of the best grades of inlaid. A range of about a dozen colors is possible, while the number of patterns is, of course, unlimited.

Hints on Buying

An important point to be carefully noted when receiving bids on linoleum floors is that the price named should be either for the square foot or square yard of floor area actually covered, or lump sum for the entire job. Otherwise, a price "per square yard of linoleum needed" is likely to be named. This involves a waste of four or five per cent, which is practically unavoidable when installing linoleum floors. But when a price "per square foot of floor area covered" is quoted, it means that the contractor, being forced to absorb all waste, will cut the waste to a minimum. The purchaser of linoleum, therefore, will do well to obtain goods manufactured according to Navy Standard, and then have his floors installed by a contractor who is willing to quote either a lump sum price or a price based on the actual footage of floor-surface to be installed.

It is possible to purchase linoleum that is guaranteed by the manufacturer to give lasting satisfaction and to have floors installed by contractors, who give a definite guarantee on their work. Dealing with such concerns, even at a slightly higher price, is naturally much to be desired.

Proper Laying Very Important

To insure a permanent and satisfactory linoleum floor, its installation must be properly made, just as is the case with practically all types of floor construction. In new hospital construction, linoleum is often cemented directly to the concrete floor base. This will make a satisfactory floor provided that a high-grade, waterproof linoleum cement is used, and, further, that the concrete floors are entirely free from moisture. Installing linoleum over a "green" concrete base is never practicable, even though the base is first treated with some efficient waterproofing material. Linoleum should not be laid until all the moisture has dried out of the floor.

Linoleum can also be readily installed with cement on wood floor bases in new construction or over old wooden floors in buildings being renovated. The essential points are to make sure that no moisture is present and that all floor bases are made smooth before the linoleum is installed.

A heavy felt or building paper is sometimes laid over the sub-floor, and the linoleum then laid over the felt. Each material is tightly cemented to the other. Certain advantages are claimed for this method of installation, particularly in the case of wood floors.

If necessary, linoleum may be laid over practically every other kind of floor, but it is highly recommended that the hospital architect seek the advice of a leading linoleum floor contractor before specifying such work, since exceptional conditions might require special methods of installation. Under any circumstances it will pay to have installation made by a thoroughly experienced linoleum contractor, who can point to other satisfactory jobs completed as evidence of his workmanship.

Proper Care of Linoleum Floors

Strong caustic or alkali soaps should never be used for cleaning linoleum, inasmuch as they cause disintegration of the material. The proper way to clean linoleum is with mild soap, preferably a vegetable soap and tepid water. Small areas should be done at a time, mopped first with soapy water, then with clear water (using always only a minimum amount of water and never "flooding" the floor), followed with a brisk, speedy drying.

Waxing and oiling prolong the life of linoleum. Any of the regular oil and wax preparations on the market may be used. An application every two or three days, after the linoleum has been swept and cleaned, will be found to keep the colors bright and the surface nicely polished and protected.

When linoleum is subjected to heavy wear, a varnishing once or twice a year will be found practical, although tending to reduce the resilient quality of the linoleum. It will cover the linoleum with a protective surface and prolong its life. It is not necessary to wax or oil linoleum that has been varnished, unless a very high brilliant finish is desired. Linoleum that has been oiled, however, should not be varnished.

Inlaid linoleum and cork carpet may be treated in just this way with one exception—cork carpet must not be varnished. Its chief charm is its softness and resiliency. Varnishing would harden it, and is, therefore, neither desirable or advisable.

HEALTH TAX UP FOR DISCUSSION

A very extensive propaganda for a health tax in British Columbia has been carried on, so successfully that the new legislature which will convene in January will seriously consider the adoption of such a measure in the province of British Columbia, it is hoped. During last year a Health Commission made a survey of the province and its report will come up before the legislature. It is also rumored that a Ministry of Public Health in the province of British Columbia will be appointed, and it is assumed by several in authority that hospitals may be transferred later into this department. However, the future promises to bring with it considerable development of a new policy for our institutions.

Never let your love for your profession overshadow your religious feeling. Depend on it that religion will strengthen, not weaken, your energies, and will not only make you a better sailor, but a superior man. Professional studies are not to be neglected; but, on the other hand, take care how you fall into the common error of believing that they are the remedy of all the ills of life.—
B. R. Haydon.

HANDLING CRACKED ICE IN THE HOSPITAL

ONE of the details of hospital administration to which the principle that "anything that is worth doing at all is worth doing well" may be applied with profit, is the handling of cracked ice. Some superintendents are not satisfied with their method. If you are among them you may find it worth your while to know how some other hospitals who have written us on this subject, handle the problem.

From Dr. John Bresnahan, who, as our readers know, went from the American College of Surgeons not so very long ago to become superintendent of the Bridgeport Hospital, Bridgeport, Conn.:

"In some of the wards the nurses used a hand ice-cracker which made a terrible racket. In other wards, they used a canvas bag and a mallet to break the ice, with the result that at two o'clock in the morning a number of patients would be awakened. It was found also that the damage done to the ice boxes with the ice pick, and to sinks where ice was broken, as well as to rubber ice bags, make it necessary to find a practical method which would stop the wastage of ice at forty cents per hundred pounds, as well as save the above named equipment and avoid the careless use of the ice pick wielded by special nurses who were not always under good hospital discipline.

Cylindrical fireless cooker used as cracked ice container at the Bridgeport Hospital, Bridgeport, Conn.

or ten hours, this was fairly well melted.

"The next step in the experiment solved the problem: We secured a number of low priced cylindrical fireless cookers. The usual two compartment food container was replaced by a single ten quart container and each afternoon these containers are filled with the cracked ice by the ice man, and, providing the nurses keep the cover on after taking ice from the container, the cracked ice lasts until the following day."

From Dr. C. W. Munger, superintendent, Columbia Hospital, Milwaukee, Wis.:

I believe that the use of fireless cookers as ice containers would be very successful and a very good arrangement to install in an old building which has no ice containers built in.

"I am sure that I prefer the type which we have, which is an insulated drawer at the bottom of each refrigerator. These drawers are drained so that such water as collects from melting is disposed of. Lying in water does not accelerate the melting of ice unless warm water is being introduced, but the presence of water renders the handling of the ice somewhat difficult.

No Ice Should Be Cracked on the Floor

"I agree with Dr. Bresnahan that no ice whatever should be cracked on the floor where patients are housed. A central machine for cracking ice does the work much better at perhaps one-tenth the expense if the value of nurses' time is considered.

From Dr. L. A. Sexton, superintendent, Hartford Hospital, Hartford, Conn.:

"It is pretty generally recognized that anything that is worth doing at all is worth doing well. I do not know of any small detail to which this is more applicable in hospitals than the handling of cracked ice.

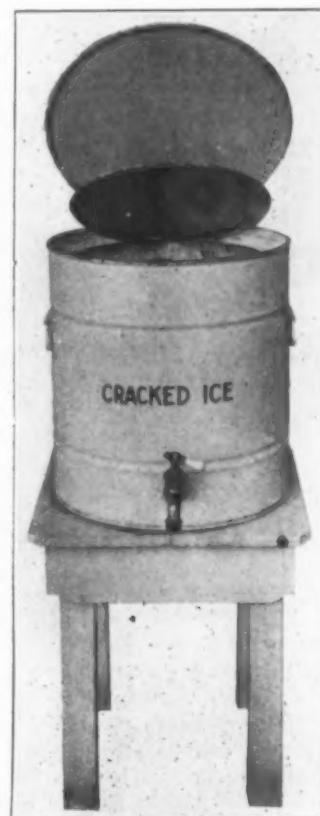
"It is necessary that this be properly handled if we are to save our ice, our hospital property, the good disposition of our nurses and their time. If a sufficient supply for use day and night is not furnished through the proper channels it is then necessary for the nurse to crack it as best she can. We are all more or less familiar with the results when this method is used.

Proper Type of Container First Consideration

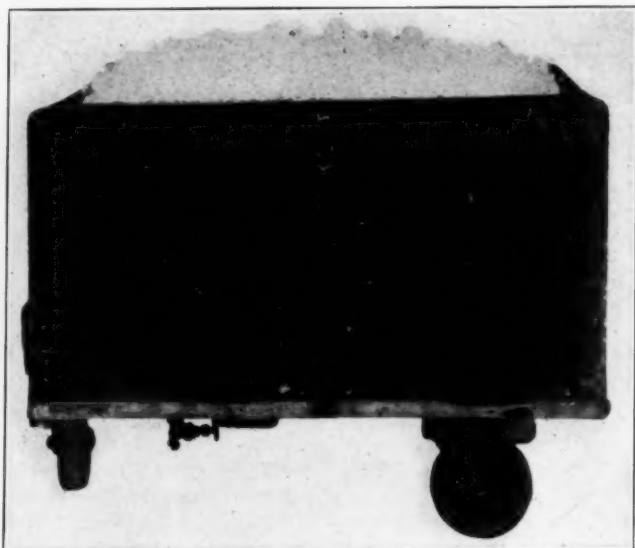
"The first consideration in the handling of cracked ice is the proper type of container for the wards or service rooms. The containers which we use (shown below) were made by our own force at a very reasonable cost and have been very satisfactory. The principle is a pail within a pail and the intervening space insulated with sawdust. The inner chamber is made of heavy galvanized iron (22 gauge), has a diameter of fourteen inches and is sixteen inches deep. When filled it holds sixty pounds of cracked ice. The outer shell, also made of galvanized iron, has a diameter of eighteen inches and is nineteen inches deep, with a wire edge top. As will be seen from these dimensions, when the inner shell is in position there is a two inch space on all sides and at the bottom. This is filled with dry well cured sawdust. This brings the top of the inner shell to within one inch of the top of the outer shell. The purpose in having the inner shell one inch lower than the outer is twofold. First, there is a collar soldered from the top of the outer shell which slopes down and is soldered watertight to the inner shell. This serves as a drain and protects the insulation. Secondly, the one inch dead space between the two tops prevents the ice from melting. We find it necessary to fill containers of this size twice daily.

"The second consideration is the best type of machine to use for breaking the ice. There are all kinds and sizes of ice breaking machines on the market. The best type will depend altogether on the amount of cracked ice an institution uses daily. We use a power driven "Creasey." These are supplied with a tight and loose pulley and can be connected to any shaft or motor driven.

"The third and last consideration is the best type



Cracked ice container used at the Hartford Hospital, Hartford, Conn. This container is made by the mechanic of the hospital at a reasonable cost and has proved very satisfactory.



Conveyor used in supplying ice to different parts of the Hartford Hospital.

of conveyor to use in supplying ice to different parts of the hospital. It is desirable that whatever type is used be water-tight, except for the drain, so that the 'ice man' cannot be traced from floor to floor by leakage and ice scattered along the way. We made a box for this purpose about four years ago that has been very satisfactory (as shown above). This box is made of one and one-half inch cypress material lined with twenty gauge galvanized iron, has metal corners and rim. It is mounted on three eight-inch ball bearing rubber tired castors. The front wheel in addition to being ball bearing is ball swivel. The box is twenty-four inches wide, inside measurement, twenty-four inches deep, and forty-four inches long and holds 410 pounds of cracked ice.

"In the Hartford Hospital, where we handle approximately ten thousand patients annually, this work is done by one man. His duties consist of filling the cans in the ice plant, drawing, breaking and distributing the cracked ice and keeping the hospital supplied with filtered water."

From Mr. Frank E. Chapman, director, Mount Sinai Hospital, Cleveland, Ohio:

"We have a central ice breaking machine, the Creasy, that is located in the ice storage room, and from which cracked ice is distributed by a representative of the dietary department, three times a day in the summer time, and once a day in the winter time.

"We have a special cracked ice receptacle in our ward ice boxes. I am not so sure that that is the ideal installation. For one who could afford it, a cracked ice receptacle in the utility room would probably be preferable."

Dr. Babcock Has Refrigerating Plant

From Dr. W. L. Babcock, superintendent, the Grace Hospital, Detroit, Mich.:

"1. The hospital has a twenty-five ton refrigerating plant and manufactures all the ice used in the main hospital and the west side branch hospital, which is managed as a branch.

"2. Ice is pulled from the freezing tanks once daily and stored in a cooler room. An ice crushing machine driven by motor is maintained at the entrance of this cooler house. Any quantity of cracked ice can be provided in a few minutes.

"3. The cracked ice which is manufactured from dis-

tilled water is distributed by the porter to refrigerating boxes, refrigerated by the ice machines. This cracked ice is used for cold drinks and for ice bags.

"4. We have had manufactured for our ice boxes, which are seventy-two by forty-eight by twenty-six inches in size, a square heavy galvanized iron box with rolled edges. This receptacle for cracked ice occupies the bottom compartment in each refrigerator. With the box we have an aluminum or heavy tin scoop for dishing out cracked ice.

"5. No cracking of ice is permitted in any wards or corridors."

From Dr. Renwick R. Ross, superintendent, Buffalo General Hospital, Buffalo, N. Y.:

"Our ice is made from distilled water, it is then cracked into pieces about one inch square by a 'little giant' ice cracker. It is transported twice daily to various refrigerators and kept in square receptacles with perforated bottoms."

Kept in Sliding Iron Boxes

From Dr. W. G. Nealley, superintendent, the Brooklyn Hospital, New York City:

"Our ice for drinks, ice bags, etc., is delivered twice a day to the diet kitchens of the wards, where it is kept in sliding galvanized iron boxes which fit in the lower section of the refrigerators. We had an ice breaking machine but it was not satisfactory and at the present time the man who delivers the ice cracks it with an ice chopper before taking it to the wards."

From Mr. E. S. Gilmore, Wesley Memorial Hospital, Chicago, Ill.;

"At this hospital we have ice in a compartment of our refrigerator. Near it is an ice crushing machine, run by motor. The orderlies have pails, built on the plan of a fireless cooker, which they take to the refrigerator when in need of cracked ice. They break up the ice with the ice crusher and carry the pail to the ward needing it, where, because of the make of the pail, the ice does not melt readily. The nurses fill their ice caps from the pails."

Ice Man Delivers to All Wards

From Dr. Harold W. Hersey, superintendent, New Haven Hospital, New Haven, Conn.:

"In the New Haven Hospital ice is produced in our own plant. A supply is stored in a large central ice box located in the general kitchen and pastry room in a room housing the ice cream freezers and ice cracking machine. From this central point the wards and other departments are supplied by the ice man.

"The cracked ice used throughout the hospital is cracked in this room by an electrically driven number four Champion ice cracking machine.

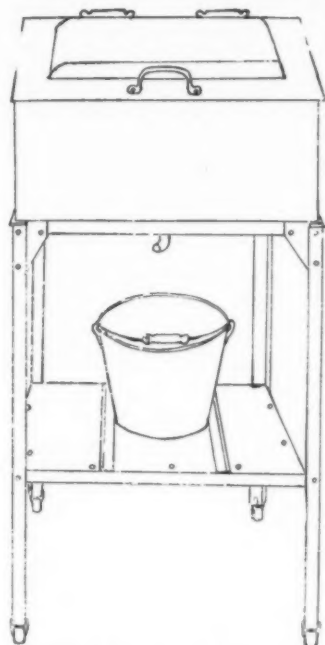
"A quantity sufficient to supply the wards is prepared and washed each morning and loaded aboard a metal lined box truck which visits each ward. From this truck a twelve quart galvanized iron pail is filled and placed in the ice compartment of each refrigerator, where it is available for use in ice caps or for other purposes. This method reduces wastage appreciably and allows the use of ice for refrigeration.

"Later in the day, or about 4 p. m., another supply of cracked ice is made as above indicated, and distributed to the wards in the same manner. These two deliveries, with the exception of a few days in summer, is sufficient for the twenty-four hours. In extremely hot weather our deliveries are made three times a day.

"A key to the central ice box is kept in the training

school office, where it is available day or night to meet any additional need for ice; but such needs arise very rarely."

A cracked ice container that is economical and satisfactory has been devised in the workshop of Grant Hospital, Columbus, Ohio. It is made of 26 gauge galvanized iron, 13½ inches wide, 20 inches long and 9 inches deep. The inch space between the two boxes is packed with cork shavings. The lid is also double with cork shavings between. The trap at the bottom is made of three-eighths inch galvanized pipe to keep the air from circulating.



"The illustration of our cracked ice container largely speaks for itself," says Miss Mary E. Jamieson, superintendent, "as it is made in our own workshop. We have them on every floor and would not

be without them. Our refrigerators keep much cooler since we do not have to open them frequently to get cracked ice. The ice is brought from the ice plant, cracked, thus preventing any noise on the floor."

HOW DO YOU TEST YOUR FLOUR?

There is a natural tendency on the part of hospital dietitians and other individuals in charge of the preparation of foods to take flour pretty much for granted. This may be a perfectly safe procedure as regards many standard makes of flour, yet every purchasing agent, particularly every dietitian or chef, should know some of the simple tests by which all flours may be tested.

In trade circles flours are generally divided into two classes, soft wheat and hard wheat flours. In determining quality the grading is along the line of purity with respect to bran, germ substances and other refuse. Generally accepted, the main grades of flour are:

Patent flours—high, short or fancy; standard; long.

Straight flours—full, regular or standard straight; cut straight; stuffed straight.

Clear, or bakers' flour—first clear; second clear.

Low grade, red dog.

These terms have only an incidental value to the baking or culinary properties of flour or to its nutritive value.

Patent flours are from the central portions of the kernel and are very free from refuse. A short patent is supposed to be composed of a smaller and more select portion of the flour than long patent, and standard patent is between the two grades, the grade being indicated by a percentage.

Clear grade flour is composed of that flour producing portion of the kernel which remains after the patent has been removed and naturally contains a considerable portion of refuse.

Straight flour is composed of the entire flour producing portion of the kernel. A "cut straight" is one which lacks some of the purest strains of the mill run. A "stuffed straight" is one to which some clear or low grade flour from another wheat or another mill run has been added.

So much for the grading of flours. The most satisfactory and the most natural test of flour is to bake it in the form in which it is desired. There are, however, other indications from which a comparatively accurate gauge of quality can be made. These indications include the color, odor, taste, feel and granulation.

Whiteness in flour is not always an indication of superior quality. In many instances whiteness indicates inferiority or the use of a bleaching process in manufacture which may be detrimental. In the early days of the milling industry, when manufacturing processes were much more simple, white flour could only be produced from the central portions of the wheat kernel, and for this reason whiteness in flour indicated possibly greater quality.

In modern methods of milling, however, the waste can be separated from the outer portions of the wheat and can be made as white as the heart flour, so that today whiteness can only be considered as showing freedom from refuse.

Bleaching processes are sometimes used, but such methods are not always in accordance with existing laws and in all cases bleached flour must be so labeled.

Hard wheat flours have a natural creamy or yellowish white color. A gray ash color is supposed to indicate refuse matter, and this can often be determined through the use of a magnifying glass, which shows the refuse matter clearly as black specks.

Good flours should have an odor and taste like freshly ground wheat. There should be complete absence of sourness and disagreeable odors.

When squeezed in the fingers, good flour falls apart easily, but retains the impression of the fingers. This method is a good way of distinguishing hard and soft wheat flours, as hard wheat flour falls apart more readily.

Flour should not contain so much moisture as to form pellets when rolled in the hand. Dampness can be detected by thrusting the hand into a quantity of flour.

Good flour should show some slight grittiness when rubbed between the fingers; one should also be able to detect this with the teeth. This characteristic is generally more noticeable in hard wheat than in soft wheat flours.

The crumbs from baked loaves is one of the best indications of the quality of flour.

The strength of flour can best be determined when mixed with about half its weight in water and thoroughly kneaded. A strong flour will produce an elastic dough, which will hold its shape and will not stick to the fingers, while weak flour will give a sticky dough which does not hold its shape.

It might be well to state that it is almost needless to test standard makes of flours made by reputable millers, whose effort has always been directed toward standardization in both methods and products.

CONDENSED ORANGES

A California concern has recently perfected a process by which the essential components of the orange can be delivered to the consumer in small cubes. From these cubes it is said jelly or marmalade can be made at a cost of one-third of the present retail price. Moreover, it is claimed that the use of these cubes will produce a better brand of jelly or marmalade than is generally offered.

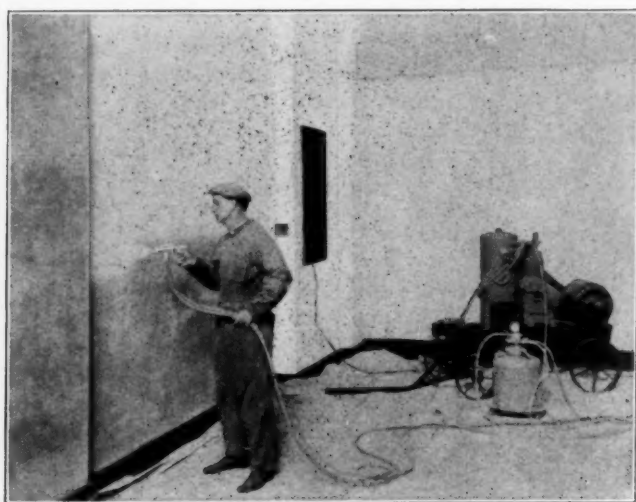
This process utilizes the by-products of the orange groves, oranges which are not in condition to be marketed at a distance being utilized in the making of these cubes.

SPEEDS UP HOSPITAL PAINTING

Painting in the hospital has become more or less of a routine job. In fact, in some of the larger institutions a force of painters is kept busy almost the entire year, renewing walls. The necessity for frequent repainting in the hospital is obvious. Not only is it necessary to keep the building attractive, but frequent cleaning of both walls and woodwork undoubtedly hastens the need for repainting.

One of the big problems in every hospital, whether large or small, is to get this painting done as quickly as possible. In the last few years almost every hospital has been taxed to its capacity, and it is difficult to spare a ward or room long enough to have the necessary painting completed.

For this reason hospital executives should be greatly interested in power painting by which the paint is sprayed



A portable outfit for power painting makes the redecorating problem in hospitals much less burdensome.

on the wall surface by means of compressed air.

This method has been largely used in industrial plants where stationary installations are employed in the finishing of various products. A portable outfit is now marketed, however, which makes this equipment readily adaptable to hospital requirements. The portable outfit for hospital use consists of a hand truck on which are mounted an electric motor, air compressor and air tank. The operation of this equipment is fairly noiseless. The compressed air is carried by pressure tubing to a smaller container mounted on casters which is shown on the floor in the illustration. The air pressure forces the paint through the hose to the "spraying gun" where it is under the constant control of the operator.

The advantages of power painting are numerous. Not only does it paint at least five times faster than hand brushing, but it uses less paint and eliminates waste. The operator, furthermore, is able more easily to reach places difficult of access, for the paint sprayed on under air pressure forces its way into every crevice, insuring a more perfect and sanitary job. Particularly is it far easier to paint over-head surfaces by this method. When applied under power the paint is sufficiently distributed, and laps and brush marks on the surface are prevented.

The air pressure outfit can be used with a wide range of paint materials, including oil paint, enamels and flat wall paints, either water or oil.

The outfit is extremely easy to install and can be con-

nected with any electric light outlet, thus making it adaptable for use in every part of the building.

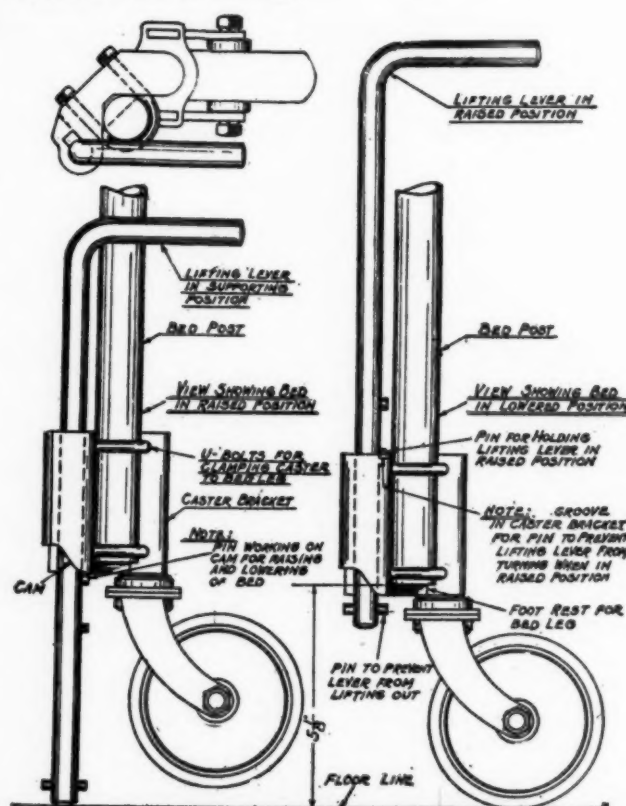
Inasmuch as this outfit enables an operator to cover 500 or more square feet in an hour, it can easily be seen that the average private room in the hospital can be completely refinished in a comparatively short time and be again ready for occupancy.

NEW CASTER MEETS NEED

One of the big objections to the use of casters or wheels on hospital beds and operating tables has been the difficulty in so locking the casters so as to make the bed or table absolutely rigid. Effort has been made to accomplish this by means of brakes on the casters themselves, but, as a rule, these have not proved thoroughly dependable. Certain manufacturers have also offered devices by which the bed or table posts are extended, raising the caster off the floor and anchoring the furniture securely. Such equipment must be "built in" to the bed or table and is practical only in original installations.

A new caster set is now being marketed by an established manufacturer of casters and wheels which apparently has many advantages over the others. One of its essential features is that it can be attached to beds or tables already in use and which are equipped with ordinary caster without a locking device.

By the use of U-bolts, the caster set is securely clasped to the leg of the table or bed. The caster proper is of high class manufacture. The rubber tired wheels are four inches in diameter and are mounted on a machined bearing that not only insures easy operation but continued dependability. This bearing overcomes the difficulty that many institutions have found in caster sets, as it is so carefully mounted there is no chance for excessive wear or binding.



Cut at the left shows caster raised from the floor with weight resting on lifting lever. Cut to right shows lifting lever raised and weight resting on caster.

As the illustration shows, the locking device consists of a lever which can be dropped through the head casting. The lever is given a half turn and a lug or pin working on a simple cam elevates the bed or table about one-half inch from the floor and anchors it securely.

The simplicity of this device, combined with the sterling qualities of the caster construction and the fact that it can be adapted to furniture already in use, should make it an extremely useful as well as economical caster for many institutions.

BLANKET FACTS

The purchase of blankets in the hospital is a serious problem. Not only do such purchases reach a considerable volume in the course of a year, but there is a serious lack of expert information on the subject. This lack of definite information on blanket quality is not confined to hospital executives, but is very apparent in the purchasing for hotels and similar institutions, and likewise in many mercantile establishments.

This statement does not reflect on the buying acumen of hospital executives or on their intelligence or keenness. On the contrary, blanket quality represents one of the most difficult problems to solve, even by experts.

It is almost a universal custom to buy blankets solely by weight, size and material. Even when it comes to material there is great uncertainty. The recent high prices for materials entering into blanket making, combined with the existing lack of technical knowledge on the part of the buyer, has resulted in the widespread marketing of blankets, presenting all outward appearances of quality, but lacking in those elements necessary for blanket satisfaction.

This decision has reacted against those firms selling blankets of acknowledged quality and in many instances has made the buyer unduly suspicious of the products of all concerns. It is hoped that these unfortunate experiences in which many hospitals have shared will prevent the indiscriminating purchase of blankets in the future.

The United States Government has recognized the difficulties in determining blanket values. The national bureau of standards, Washington, D. C., has devoted considerable research and study to the testing of textiles, including blankets. The results of their tests are available to all buyers. In fact, institutions or firms purchasing large quantities of blankets will be amply justified in submitting samples of the blankets they are considering to the bureau of standards and have an authoritative test made of the relative quality of the various samples.

It is obviously impossible for the everyday institution to submit samples of their blankets purchased for laboratory tests. There are, however, certain established conclusions which should aid them in making their selection. There are certain fundamental factors which must be considered in judging a blanket's usefulness for institution use. These factors include warmth, strength, thickness and fibre content. If the buyer will judge the sample blankets from the standpoint of these essential factors, he will be able to reach a more logical and intelligent conclusion.

The fundamental quality of the blanket is warmth. This means that the value of a blanket as protection against cold lies in its ability to prevent the passage of air through the blanket. Scientific tests in which the amount of heat transmitted through various materials was measured, brought out these facts.

Heat retention is not dependent upon weight alone.

Heat retention is not dependent upon the fibres used.

Heat retention is not dependent upon thickness alone.

The greatest determining factor affecting the impervious-

ness of a blanket is the arrangement of the fibres.

From these facts it is readily seen that the actual heat retaining qualities do not depend on whether a blanket is made of wool or cotton, but rather upon its construction. Even casual examination of blanket samples will enable the buyer to determine relatively which sample is least impervious to the passage of air.

It must be remembered, however, that this is only one factor to be considered. The warmest blanket, i.e., the blanket with the great heat retaining qualities, is not always the strongest or the most durable blanket. The so called "napping" process naturally reduces the strength of the blanket to some extent, because the surface of the yarn is broken to form the nap. It is readily seen, therefore, that the desirable blanket is one that combines wearing quality and heat retaining quality in such measure that too great a sacrifice of one has not been made to enhance the other.

The strength of a blanket is determined primarily by the tensile strength. This can not be accurately determined without a proper measuring device. Even casual testing of this factor will be of assistance to the buyer, and will enable him to avoid the purchase of blankets lacking proper strength to a marked degree.

The thickness of a blanket must be considered in connection with its warmth and in such consideration thickness and weight are almost synonymous. The purpose for which the blanket is to be used, climatic conditions, the temperature of the room, must all be considered when deciding upon the thickness of the blanket to be purchased.

It may surprise many to learn that wool and cotton blankets can be made equally warm and strong if properly constructed. There has been a tendency to regard wool blankets as necessarily representing a higher quality than cotton or part cotton blankets. This fact does not necessarily follow; everything depends upon the length of fibre, the method of construction, and the imperviousness of the fabric. Do not, however, understand us to say that there is no difference in the value of wool and cotton blankets. If both are equally well constructed there is a difference and this difference lies mainly in the resistance to the wear and tear of laundering, which affect different fibres in different ways. Frequent laundering is apt to destroy the effective heat retaining qualities of the blanket by destroying the nap and likewise decreasing the strength of the blanket, and in this respect cotton blankets frequently prove inferior to wool or part wool blankets.

It is not within the scope of this article, however, to discuss the relative merits of cotton and wool blankets, but rather to discuss those essential facts important in the purchase of either.

The purchase of blankets in the hospital must frequently be figured from the standpoint of cost, which will affect the decision as to the kind of blankets purchased. Even this condition, however, should not prevent the buyer from securing the best blankets possible for the available money.

OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by HERBERT J. HALL, M.D., President, American Occupational Therapy Association,
Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS,
Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and
MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

CHRISTMAS AT THE MILWAUKEE CHILDREN'S HOSPITAL

"How many days until Christmas?" "May I write a letter to Santa Claus?" "Will my mat be finished to give to mother on Christmas?" "Will Santa Claus come in an aeroplane?" How many reindeer has Santa Claus?—these are the questions that are uppermost in the minds of our little patients from the time when cold December makes his appearance until Santa has emptied his pack and the last tinkle of his bells has died away. For Santa Claus comes every year, a jolly, jingling, dancing, old fellow, giving his toys to each patient and listening to their Christmas greetings and songs.

Many a poor child, while sick at the hospital, obtains his first conception of the spirit of Christmas and the fulfillment of his most cherished dreams. To see the eager faces at the windows waiting for Santa Claus, to hear the first shrill voice cry, "There he is!", and to watch the puzzled faces as Santa, by mistake, ascends the steps leading to the house across the street—then the shouts of joy as a nurse leads him to the hospital door is more than thrilling to the interested spectator.

There was an abundance of Christmas cheer at the last celebration. Besides all the gifts for each individual child, Santa Claus presented the children with a Victrola bought under favorable conditions from the sale of articles which the patients made during the year. The little ones hope that by being good and industrious, Santa Claus will present them this Christmas with another gift as enjoyable as the Victrola.

So it is with eager anticipation, increased by oft-repeated stories of last season's happenings, that the children at the Milwaukee Hospital await Christmas of 1921.

THE CHRISTMAS SPIRIT

The writer has always been a little troubled by the Christmas Spirit—it is so soon over. For weeks the Salvation Army lassies stand out on the cold corners collecting money for one good hearty Christmas dinner to satisfy the hunger of thousands for one day. All delightful and appropriate, but what about the other three hundred and sixty-four days?

We cannot feed the world out of our charitable pockets. We cannot provide a continual Christmas feast even for the poor and helpless. The communistic idea is very attractive, but many sad experiments have shown that it is not practical. "If any would not work, neither should he eat" is a hard saying, but there is a deal of justice and necessity wrapped up in it. The dictum is derived from principles which in the main are right, and essential for the welfare of the world. Let us have the Christmas Spirit by all means, let us sing our carols, hang our wreaths, and fill up the empty stomachs, but those who think seriously and who wish to do their part in the service of humanity will be considering the other three hundred and sixty-four days, and the very great need of appropriate work for all but the actually helpless.

The great problem of adequate work for the millions is in the hands of our statesmen and our captains of industry, and it is a matter hedged about with world

old difficulties. In the presence of these problems, our little O.T. project of work for the handicapped seems small indeed, but it is a business that appeals particularly at this Season of Goodwill. Occupational therapy with its first halting steps in the retraining of the injured, the crippled, and the chronically ill, seems to us now, as we think of it, a very wonderful gift to the world of need. Surely, the charity that helps the handicapped



After Santa Claus has made his visit, Milwaukee Children's Hospital.

to help themselves is worthy of all praise and full support.

Those of us who are concerned with this very appealing phase of human helpfulness know that we have taken hold upon a very big idea, which, carried out to its fullest developments, can mean nothing less than the harnessing up of handicapped effort everywhere. We know that if, in the future, we are able to provide the materials and the supervision, we shall succeed finally in coordinating the manufacturing possibilities of thousands of otherwise helpless people, until the sum total will become a matter to be reckoned with, not trivial at all, but a very substantial step toward the feeding and housing of thousands who might be hungry or homeless during those desperate

three hundred and sixty-four days.

Occupational therapy first, then handicapped labor, organized, directed, and if necessary, subsidized. Infinite possibilities lie that way, not only a real contribution toward the material relief of the helpless, but the possibility of courage and self-respect, where these very precious elements have not existed before. If well-directed, productive energy is necessary for economic salvation of the race, then perhaps the example of the handicapped doing their part will help to shame the slackers and put them about their legitimate business.

Occupational therapy and rehabilitation are good for most of the year—we will not ask anyone to work except for pleasure on Christmas Day.

OBJECTIVES AND MOTIVATION IN OCCUPATIONAL THERAPY

By ALLAN R. CULLIMORE, FORMERLY MAJOR IN THE SANITARY CORPS, UNITED STATES ARMY, AND CHIEF OF THE EDUCATIONAL SERVICE IN LETTERMAN GENERAL HOSPITAL, SAN FRANCISCO, CAL.

WHILE the immediate functions of occupational therapy are well understood and widely recognized and while from an immediate therapeutic standpoint its efficacy is beyond question, the ultimate objective is frequently lost sight of, or at best is but hazily appreciated. It will, of course, be understood that the treatment accorded any patient in any hospital has for its goal the reconstruction of the individual to the point of highest possible efficiency. Immediately considered, this efficiency is physical and the means employed, be they medicine or surgery or both, are concerned directly with physical wellbeing. In a broader and a deeper sense, however, the functions of the physician and the surgeon are of greater significance. In addition to immediate physical well-being, whether it be recognized or not, the doctor has a responsibility which has to do with the economic, the social and the moral, as well as the physical behavior of the patient who passes under his care. And if, as has been proved, occupational therapy is a definite therapeutic agent, and if as such an agent it is really valuable, it must share responsibility ultimately as well as immediately with the physician and the surgeon.

It will be clearly seen that in cases of major amputations and in certain mental cases, the results of treatment must be specific rather than general. It would manifestly be impossible if the amputation of an arm were indicated to so perform the operation as to make the patient in a general sense as efficient as before, neither could the surgeon perhaps operate in such a way as to make it possible for the patient to take up his occupation as a machinist. It might be possible, however, for the man ultimately to become a draughtsman. It would seem better practice to work to a definite ob-

Occupational therapy planned to kill time is good in its place, but it stands in the same relation to the real occupational therapy as that of first aid to medical treatment based on examination and careful diagnosis. The occupational work must be founded on a thorough examination and enlightened diagnosis and must have a definite end in view. Moreover the patient must desire this end. The examiner after he has determined upon the end must see that all work leads definitely toward it and that every worker coming in contact with the patient understands what the objective is. One should be slow to change the objective but once changed there should be no hesitancy in its pursuit. Mr. Cullimore has found this lack of motivation and objective to be the most noticeable defect in the work of many hospitals of the United States and Canada.

jective in many cases rather than to a broadly generalized one.

This is particularly true in the case of occupational therapy, that is in the treatment of individual cases by this agent. Physically in most cases the diagnosis has been made and the treatment fixed in so far as it relates to the various forms of therapy, very probably the character and the duration of the periods of occupational therapy have been also fixed, and in very many instances the occupational guide merely fills in with "busy work" certain periods

that would otherwise be spent in solitaire, letter writing or worse. While this sort of occupational therapy is perhaps not positively bad, it is certainly negatively good and falls so far short of what ought to be done, and what can be done, that it often merits the disapproval which is given it by certain enlightened medical men.

It is doubtless true in the treatment of many cases by occupational therapy that work of the generalized or "busy work" should be given. It is true in exactly the same sense that a patient must live to be treated, and while first aid treatment is calculated to keep the patient alive until he can be put under treatment, and is therefore important, it would be criminal to consistently apply first aid in lieu of a treatment based on a thorough examination and an enlightened diagnosis.

When a patient comes under the influence of a man or woman for treatment in occupational therapy, the same immediate conditions of purely physical well-being govern as in treatment purely medical. In addition the responsibility for the ultimate attainment of a definite objective is just as great as it is on the part of the doctor.

This means that the first need is for a thorough examination and an enlightened diagnosis and then the prescribing of a definite motivated treatment with a specific

objective in view. This procedure is vital to a properly conceived system of occupational therapy. In inspecting a very great number of hospitals in this country and Canada, the one great lack was found to be in the motivation and objectives, or rather in the lack of both.

In the case of specific functional restoration by means of curative occupations and workshops, the examinations and diagnosis should be conducted by a medical man in close liason with the occupational worker, the medical man deciding the character and duration of the work and the occupational man its form, a definite distinction being made between character and form, with a frequent review from the medical side. Fortunately work of this character has been pretty definitely standardized both in this country and abroad and little that could be said here would add to the excellent books already available.

It is not, however, with specific functional restoration that the occupational worker has most to do. The problem today is particularly with specific economic and its consequent social restoration. The object of all treatments is to place the individual back into the fabric of society a self-supporting, self-respecting unit *as soon as possible*. Economically, socially, and morally, delay is costly, very costly. If we are to escape hospitalization and the host of ills of morale, we must have speed and work motivated to a definite objective. If the one sentence, "We must put the patient quickly in self-supporting work" could be hammered in again and again, occupational therapy would be a hundred times more efficient. A long extended course of treatment may result in physical health and death of morale, this is evident everywhere today. In long continued treatment physical health and health of morale are only possible in most cases by a properly conceived and motivated course of occupational therapy.

Patient Must Desire End in View

Every worker in occupational therapy must understand these generalities and must get this point of view as a background of the technique in any individual case. Occupations must lead somewhere and the patient must want to follow. It is simple and fundamental.

We must examine to find out, to diagnose. A general diagnostician is perhaps one of the hardest men to find, but in every hospital organization the need for one, from the standpoint of occupational therapy, is extremely urgent.

He should, of course, examine all patients under treatment. It is important to have this first examination very thorough and there should be no attempt to save time. It is necessary to get not only the man's occupational history but his social history and in many cases a simple psychological test is of very great benefit. The examiner should have a wide vision and a real sympathetic appreciation of many men and many occupations. After a careful consideration of all the evidence he must determine upon a single definite objective and see that any work given in occupational therapy leads directly or at least in close relation to the objective.

The objective should be discarded only when a better one is conclusively found to exist and the new objective should be followed with all the enthusiasm and single-mindedness of purpose which characterized the pursuit of the first objective. There should be a hesitancy to change, but once changed there should be no hesitancy.

The objective should be definitely understood and appreciated by every occupational worker coming in contact with the patient and the work should be so correlated, directed and motivated that the patient appreciates that

a logical and definite attempt is being made by qualified persons to solve some of his real difficulties. Faith in the occupational worker is just as necessary to progress in the case as is faith in the doctor, and faith must rest on a knowledge of work well done, that is on reputation.

The question of proper motivation from a technical standpoint is one of very great difficulty. It presupposes a staff possessing not only technical ability of a high order, but a deep understanding and a wide knowledge of things of the world in general. From a practical standpoint the only way to possess such a staff is through training and the only training worth while is through service, by clinic and by an intensive study of the case records of an individual.

From the experience of the writer the following procedure seems best:

- (1) An examination and a full record of the previous history of the case by a qualified examiner whose function it is to record facts.
- (2) A review of this examination with the patient on the part of a competent psychologist.
- (3) A diagnosis and course of treatment prescribed by an authority, which lead to a definite objective, with a fixed scheme of motivation.
- (4) The technical administration of the treatment under close supervision and with a daily record.
- (5) A review of all cases at a clinic at frequent intervals, carried through the greater part of the course of training.

The crux of any course of training lies in the objective and motivation. Of these two the motivation is as important as the objective once the latter is established, and is infinitely harder to establish and maintain.

It taxes the resources of the whole staff and in the mind of the writer can be and is much better done by women than by men. The results obtained by some women without training, even in the most difficult cases will always stand out as some of the greatest personal achievements in the reconstruction program of our army hospitals in the recent war.

A STUDY OF SUBNORMAL CHILDREN

About seven months ago a home was established on the grounds of the Jewish Hospital, which is unique in many respects and which is known as the Psychopathic Institute. The primary object of the founders is to make an intensive study of subnormal children, determine the underlying causes, and suggest remedial measures.

Classes in occupational therapy are conducted three afternoons in the week, the children being taught sewing, carpentry, weaving, pottery, and reed work. The object of this is two-fold; it is of benefit to the patient and of great help to those observing the child. The defective and retarded child who has become discouraged through his inability to keep up with the school curriculum, finds to his great surprise, that he is able to cope with concrete tasks and produce definite and constructive results. His self-esteem rises unconsciously and his whole mental attitude is changed. Nothing is more conducive to effort than the knowledge that one has the ability to accomplish or produce. While the children are busily engaged, careful observation often discloses inherent capability or disposition not previously exhibited and which may have an important bearing on vocational training and social adjustment. All these reactions are noted and finely correlated with the facts obtained from the physical and mental examinations, and this comprehensive data helps those in charge not only to make a diagnosis, but also to recommend a course for future action.—*Cincinnati Sanitary Bulletin*.

URGE HOME WORK FOR CRIPPLES

The New York State Society is actively concerned in creating sufficient interest to influence the introduction of an exemption clause, in a bill presented to the last session of the legislature, the purpose of which was to abolish home work in cities of the first and second class throughout the country. The bill failed to pass, but proponents are planning to reintroduce it before the next session. The point is being raised by this Society and various interested groups of individuals that provision must be made in the bill exempting home-bound cripples and the blind, in compliance with the law. The plea is that this helpless group of handicapped be exempt, for the reason that employment with remuneration is what is most needed to keep up the courage and morale; that this group which must work at home, while large enough to be considered, is not sufficiently large to be industrially competitive. The Women's City Club of New York introduced the bill referred to, but the chairman of the committee on tenement home work is very open to conviction concerning the exemption clause.

Pending the above legislation, Mrs. Richard Cook and Miss Lois Deveraux enter upon their duties as visiting instructors to the Home Bound, on January 3. This Society also will begin their activities with instruction for private cases.

WATCH THE POSTURE OF PATIENTS

If we are to see the best results from occupational therapy, we must be careful to avoid unnecessary handicaps, the handicaps of ignorance and carelessness which creep into convalescent progress. Among the most common of our mistakes as teachers is the failure to insist on a healthful and well balanced posture in our pupils.



A bad posture at the loom.



A good posture.

There is no better all around exerciser than the hand loom, no better machine for developing patience, accuracy, and the ability to sustain effort. But if the weaver is allowed to bend over the work, flattening the chest, crowding the abdominal organs down into the pelvis and straining the muscles of the back, he will materially reduce the value of his occupation, bring on early fatigue, and make unnecessarily slow progress.

If, on the other hand, an erect, easy balance is maintained, the work is less tiring, and the patient learns an important lesson in physical hygiene.

Sometimes a bad sitting position is favored by defective vision. The oculists frequently give their patients two sets of glasses, one for distance and one for reading. In some cases, at least, the reading glasses are good only for the regular reading distance, a longer focus may be needed for bench work, music, or such an occupation as weaving. It may be the attempt to get down to a reading glass focus that produces the bent over, flat chested posture illustrated above.

Whenever a patient shows a tendency to bad posture we must have the eyes tested. If they are all right, we are dealing with carelessness and bad habits in the patient and in the aide who fails to correct the fault.

In regulating the diet of consumptive patients, I conceive it to be as necessary to feel the pulse, as it is in determining when and in what quantity to draw blood. Where inflammatory diathesis prevails, a vegetable diet is certainly proper; but where the patient has escaped, or passed this stage of the disease, I believe a vegetable diet alone to be injurious; and am sure a moderate quantity of animal food may be taken with advantage.—Medical Inquiries and Observations (1809) by Benjamin Rush, M.D.

MEETINGS, CONVENTIONS AND CONFERENCES

DIETITIANS ENJOY STRONG PROGRAM

By ANNA E. BOLLER, RIVERSIDE, ILL.

THE fourth annual meeting of the American Dietetic Association was held at the Hotel La Salle in Chicago, October 24-27. About 500 persons were registered at the conference.

All during the convention the close relationship between dietetics and medical, nursing and social service became more evident. The three-day program was extensive and included papers and discussions on administrative problems, teaching problems, dietotherapy and social service.

Mary A. Lindsley, manager of the Grace Dodge Hotel for Women in Washington, conducted a most interesting and valuable morning session. The question of equipment was discussed from the point of view of the institution and the housewife. Miss Margaret Proctor of the Y. W. C. A. showed where many mistakes are made in planning kitchens, such as placing sinks too low, tables and cupboards at an incorrect height, and improper arrangements of equipment. She emphasized "humanizing" the home and commercial kitchen. Others on the program were George A. Smith of the Chicago Range Company and Agnes Gleason, manager of the Parkway tea room in Chicago.

The social service section meeting and round table reflected credit on the chairman, Miss Lucy Gillette of the nutrition bureau, Association for Improving the Condition of the Poor, New York City.

Miss Sophonisba Breckenridge, an associate professor of sociology at the University of Chicago, in reply to the question "To what extent should racial customs enter into any Americanization scheme?" said that they should be a part of it "to the greatest extent rendered possible by the knowledge, training, and sympathy of the persons directing the Americanization efforts." More interesting questions are, she said, how this knowledge can be increased and rendered available to a greater number of

persons and how the sympathy and tact necessary for the task can be directed towards families that are either foreign-born or not yet adjusted to American life. The American standard of living, she said, is dual: Legislative and voluntary. It is preferable that immigrant housewives should be educated to the latter standard rather than be compelled by law to live up to the former. She urged the social worker, the child welfare expert, and the domestic economist to reach such housewives and to give them instruction in modern housekeeping according to American standards of living.

Following Miss Breckenridge's talk four papers were given on "Dietary Customs of Various Nationalities."

At the meeting of the section on education under Dr. Ruth Wheeler, professor of nutrition, University of Iowa Medical College, Iowa City, Iowa, standardized courses for nurses and dietitians were presented.

"What Nurses Need to Know about Dietetics" was the subject of a paper by Miss Helena MacMillan, principal of the school of nurses of the Presbyterian Hospital, Chicago, and a recognized leader in the nursing field. The dietitian, as an educational director, Miss MacMillan declared must feel a great responsibility in helping formulate standards for nursing education. Too much routine work for the nurses must be avoided, she believes, so that more time can be spent with the instructor.

An outline for a student nurses' dietetics course by use of the project method was presented by Miss Katharine Fisher of Columbia University. Student dietitian courses were presented by Miss Octavia Hall of the Peter Bent Brigham Hospital, Boston, and Miss Mary Foley of the Rochester Hospital, Rochester, Minn. Miss Abby Marlatt, University of Wisconsin, gave an outline for two- and four-year preliminary courses for dietitians.

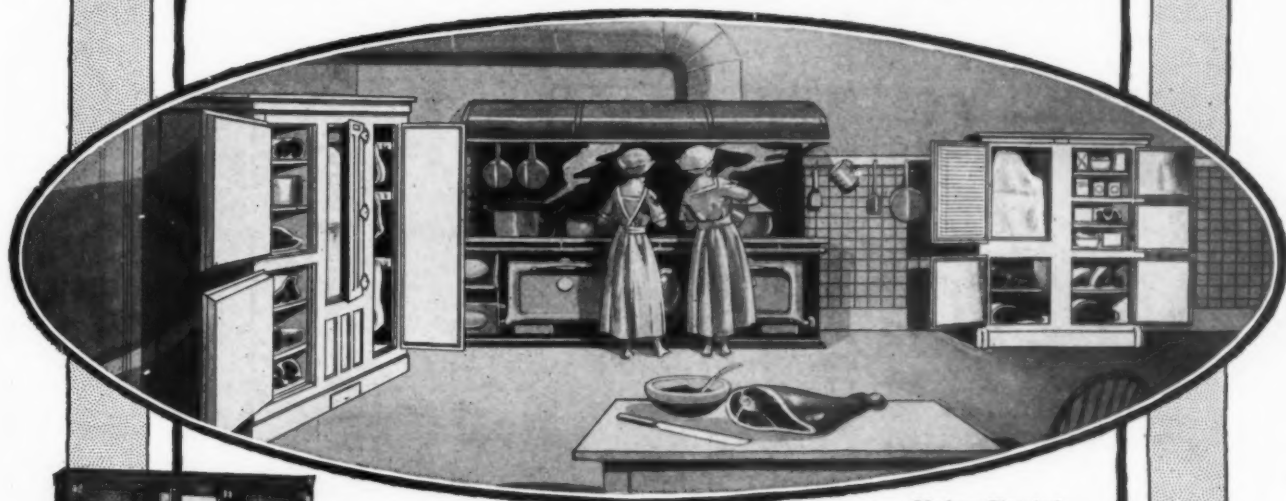
(Continued on page 542)



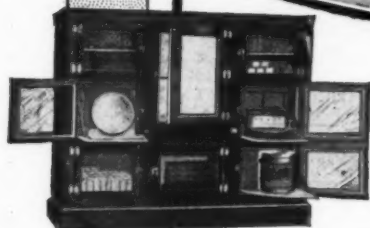
Mary DeGarmo Bryan, of Jersey City, N. J., was re-elected president of the American Dietetic Association at the fourth annual meeting, in Chicago, Oct. 24-26.

McCRAY

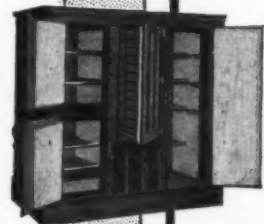
REFRIGERATORS FOR ALL PURPOSES



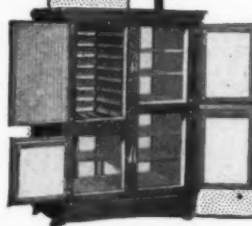
Modern Hospital
McCray Equipped



FOR GROCERS



FOR INSTITUTIONS,
RESTAURANTS, HOSPITALS,
HOTELS, CLUBS ETC.



FOR RESIDENCES



Page 616

MANY leading institutions, hotels, clubs and restaurants have used McCray Refrigerators for more than thirty years with perfect satisfaction. They have utmost confidence in the refrigerator which bears the name "McCray", for it stands for quality and unequalled service.

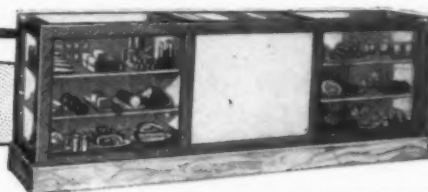
McCray Refrigerators assure positive, cold, dry air circulation—the walls are constructed of materials that have the greatest heat repelling qualities. McCrays, therefore, cut waste from spoilage to the absolute minimum.

PLANS FREE. Gladly will our service department furnish plans and suggestions for special built-to order equipment. Simply send us a rough sketch showing what you deem your needs to be. *Remember, any McCray can be arranged for mechanical refrigeration.*

SEND FOR CATALOG. Our catalogs will assist you when confronted with refrigerator problems. No. 53 for Hospitals and Institutions. No. 95 for Residences. No. 72 for Groceries and No. 64 for Meat Markets and General Stores.

McCRAY REFRIGERATOR CO.

2166 LAKE STREET KENDALLVILLE, INDIANA
Salesrooms in All Principal Cities



FOR DELICATESSEN STORES

Consult the 1920 Year Book for Catalog information.

At the dinner Monday evening, Mrs. Mary De Garmo Bryan, president, outlined the objects of the association, the work that had been done during the year, and plans for the coming year. The convention would do much, she said, toward convincing the public of the fact that the dietitian is a professional person whose training demands utmost care. During the past year the association has been instrumental in installing two courses in dietetics for nurses and a preliminary course for the dietitian in universities, colleges and technical schools. Next year a committee will compile a list of hospitals and classify them according to size, equipment and dietary standards. With this list it will be possible for students to choose hospitals offering the best training.

Diet and Mood

Miss Harriet Vittum of Northwestern University Settlement gave an inspirational talk on "Professional Spirit." Madison E. Bentley, professor of psychology at the University of Illinois, said, in discussing diet and its relation to mood:

"The moods stand closely related to the emotions. Both contain strong feeling and both involve the organism in a diffuse and general way. Anger, joy and fear are typical emotions; petulance, depression and good humor are typical moods. Moods usually last longer than emotions, and they lack the reference to specific events and situations which characterizes the emotions. The mood is a tuning or toning of experience, and it is suffused with pleasantness or unpleasantness.

"Moods are made up in large measure of the same materials that underlie the bodily perceptions of hunger, lassitude, satiety, thirst, appetite, nausea, and the like. These simple materials are pressure, pain, warmth, cold, heat, strain, fatigue, and the simple feelings. In such bodily perceptions as hunger, thirst and satiety, the function is to color and to tone our experiences and to incline us in one direction or another.

"After this analysis of the moods into their simple ingredients, the psychologist proceeds to study their kinds and varieties, and then to relate the several kinds to their bodily conditions. He finds two varieties, the reflective and the anticipatory moods, which display only a casual relation to the visceral functions, and two other varieties, the quiescent,—gloom, tranquillity, good humor,—and the turbulent moods,—petulance, restlessness, gaiety,—both of which draw largely in their origin upon those organic sensations aroused by the processes of digestion and secretion. The more detailed and accurate description and explanation of these last two classes awaits the cooperative study of the psychologist and the physiologist of nutrition."

Dietitian Not a Diagnostician

Dr. C. P. Howard, professor of internal medicine, University of Iowa, in his paper on "The Sphere of the Dietitian," stated that her sphere is the planning of diets and not diagnosing diseases. In closing he advised, "Shoemaker, stick to your last."

Professor A. J. Carlson of the University of Chicago in his address said that the dislike of certain food is a psychic idiosyncrasy with most of us, and that one of the most important tasks of the dietitian is the removal of these imaginary dislikes. This is especially true with children, he believes, and considering the almost universal anemia among them in civilized communities, one may realize that the safety of modern society depends upon training the child to be more omnivorous—that is, to be less finicky about food.

Dr. Sidney Kuh, a leading neurologist of Chicago, read a paper on the "Relationship between Diet and Nervous Conditions—with its Significance in Social Problems." He stated:

"There are no so called nerve-foods, articles of diet that have a specific beneficial effect in functional nervous trouble. Diet is usually determined by the physical condition of the patient. Coffee and tea are harmful if given in any but very moderate quantities,—coffee excites, tea stimulates. There is a difference of opinion as to the cheering effect of alcohol in cases of mental depression. It is on the whole much more harmful than beneficial and with neurotic patients there is the danger of establishing a habit.

Condemns Volstead Act

"The Volstead Act has had a bad effect, since it is prohibition which does not prohibit, as it substitutes for the bad whisky of years ago the worse whisky of home manufacture. It has not materially decreased alcoholism in men, and has led women, who under present conditions have greater difficulty in securing whisky, to an increased use of narcotic drugs.

"Monotonous diet, though it contains ample nutriment, often leads to loss of weight, anemia and tuberculosis. To vary diet as much as possible is necessary in all cases, and the importance of psychic influences in the assimilation of foods is particularly great with the neurotic. Hence appetites are influenced not only by methods of preparing foods, but almost equally by manner of serving it, the presence of congenial company, pleasant conversation, etc. For undernourished neurotic patients, one should use butter freely, both on bread and in the preparing of sauces, soups, vegetables and in the cooking of meats. Fat meats are not desirable; yolk of egg is very valuable. Consider as far as possible likes and dislikes of patients, because then they will take the largest possible quantity of food and assimilate it best. A great deal of harm is done in cases of so-called nervous dyspepsia by too restricted a diet.

"In epilepsy it is not necessary or desirable to eliminate meat altogether; it may be allowed in moderate quantities without harm to patient. A diet containing a very limited quantity of salts is of decided value in this disease. Stomach upsets and sluggish bowels very frequently bring on attacks."

One of the best attended meetings was that of the section on dietotherapy, under the chairmanship of Miss Rena Eckman, University of Michigan Hospital, Ann Arbor, Mich.

Dr. Amy Daniels of the Iowa State Child Welfare Association, University of Iowa, in her talk on "The Dietary Needs of Children," emphasized the importance of a dietitian trained in childrens' dietetics. Children have strange idiosyncrasies and these must be corrected to better future generations, she declared.

Prevention of Simple Goitre

Dr. O. P. Kimball of the Medical Department of Cleveland Clinic, Cleveland, Ohio, gave an interesting and valuable discussion on the "Prevention of Simple Goitre," in which he said:

"The practical application of prevention of simple goitre in man was carried out through the public schools of Akron, Ohio, from 1916 to 1920 by Drs. Marine and Kimball of the School of Experimental Medicine, Western Reserve University. Since 1920, it is being carried on as a public health measure by the school authorities. On account of the extraordinary results obtained in Akron.

Strength and Pliability are Found in

Armour Iodized Sheep Gut Ligatures

which are made from lamb's gut selected in our abattoirs especially for surgical purposes.

The *Armour Iodized Ligatures* possess full tensile strength and their pliability prevents breakage at the knot. They are iodized to the core and are absolutely sterile. Regular lengths, sizes 00 to number 4 at \$2.50 per dozen.

We also offer *Plain* and *Chromic Ligatures*, sizes 000 to number 4 regular lengths \$2.50 per dozen, emergency lengths, \$1.50 per dozen (nothing but the smooth side of the intestine is used in the manufacture of the Armour ligatures).



Suprarenalin Solution, 1:1000 is stable, uniform and free from preservatives.

Pituitary Liquid is physiologically standardized and is ready for hypodermatic use— $\frac{1}{2}$ c. c. ampoules for obstetrical and 1 c. c. ampoules for surgical use.

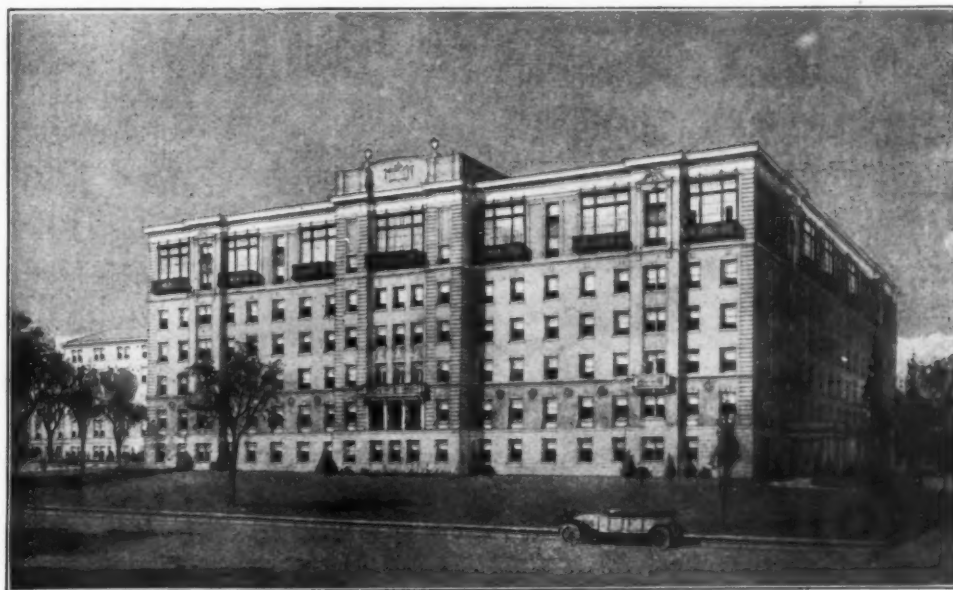
Literature upon the ARMOUR LABORATORY PRODUCTS for the medical profession only.

ARMOUR AND COMPANY
CHICAGO



Page 277

Headquarters for the endocrines and other organotherapeutic products.



THE use of over 2,000 Roddis Flush Doors in St. Mary's Hospital, Rochester, Minnesota is an important detail that contributes to the acknowledged excellence of that institution.

Doors Stamped



Your Protection

Roddis Flush Doors meet the exacting requirements of institution use. Solidly built, glued with waterproof glue, the flush surface offers no opportunity for dust or germs to collect.

RODDIS LUMBER & VENEER CO.
27 years at Marshfield, Wis.

it is being carried out as a public health problem by the schools in six Ohio industries where girls are employed. Several school systems of Michigan and Wisconsin are taking it up. Following the work in Akron, it was started in the schools of Zurich, Switzerland, and they obtained such results that it has recently been adopted by the goitre commission of Switzerland to be carried out throughout the whole state as a public health measure."

Dr. R. T. Woodyatt, assistant professor of medicine, University of Chicago, read a paper on "Newer Ideas on the Diet Management of Diabetes and Their Practical Working Out in the Hospitals." He told of the work in the Metabolic Clinic at the Presbyterian Hospital in Chicago.

Mr. John Street of the National Canner's Association talked on "Food Poisoning," in which address he told about an investigation of and an experiment with canned foods.

Mrs. Gertrude Mudge of the nutrition bureau, American Red Cross, read a well organized paper on the necessity to work with the family as a whole. She feels that more work should be done with the child of pre-school age.

Business Session

A business meeting was held Wednesday morning and the following officers were elected for the ensuing year:

Mrs. Mary de Garmo Bryan, president, editor of the *Journal of Home Economics*.

Helen Pope, first vice-president.

Octavia Hall, second vice-president, dietitian, Peter Bent Brigham Hospital, Boston, Mass.

E. M. Geraghty, secretary, student, University of Illinois.

Ellen Gladwin, treasurer, dietitian, Jefferson Hospital, Philadelphia.

The Chicago Dietetic Association, acting as hostess, planned a series of professional trips for Thursday. About 150 persons stayed over for the day. The three trips were as follows:

1. To hospitals—Presbyterian, Cook County, Michael Reese.

2. To commercial institutions—Sprague, Warner & Co., Marshall Field's tea room, Swift & Co.

3. To welfare centers—Infant Welfare Society, Association of Housekeeping Centers.

After the trips the three groups met for the closing luncheon at the Chicago Beach Hotel, after which a trip through the University of Chicago was scheduled.

The commercial exhibit was large and interesting. Miss Geraghty planned it to cover all lines of special interest to the members in the various fields. The exhibit included such things as: Well known beverages served in new ways, package meats, suggestions for utilizing less expensive cuts of meat, two types of dishwashing machines, heavy duty electrical equipment, two types of electric toasters, an excellent bread slicer, a mixing machine, fancy groceries, staple canned goods, two cleaning powders, and a food cart.

The non-commercial exhibit, as planned by Mrs. J. W. Martin, Miller Hospital, St. Paul, contained many valuable charts, posters, etc.

TO CORRECT AN ERROR

Through an inadvertence in the November issue of *THE MODERN HOSPITAL*, the reproduction on the cover of the Good Samaritan Hospital of Cincinnati was labeled St. Elizabeth's Hospital of Cincinnati. The management hastens to correct the error.

HOSPITAL ORGANIZATION IN NEW ZEALAND

New Zealand hospitals may boast of some advantages over their sister institutions in America. Among them is their privilege to levy for their needs upon municipalities and counties, such levies carrying government subsidy. Hospitals of the commonwealth are administered by boards consisting of representatives of contributory local authorities.

The New Zealand Division of Hospitals under the Department of Public Health, Hospitals and Charitable Aid possesses full inspectorial powers. The department under which the Division of Hospitals comes has two technical inspectors, who closely examine all plans for buildings before the Minister is recommended to give his consent to their construction. No capital expenditure of more than 250 pounds can be undertaken without the precedent consent of the Minister.

The Department has a supplies bureau which undertakes the purchase of supplies for hospital boards which wish to avail themselves of this service. The services of the Department's inspecting accountant and consulting engineer may always be obtained by hospital boards. A system of hospital accounts uniform in regard to form, is in use but no attempt has yet been made to insist that a uniform set of books be kept by each institution.

Lethargic hospital administrators, under the New Zealand system, it is said, are inclined to lean on the government department in many instances rather than use their own energy and initiative. Two years ago the department called a conference of hospital boards and some of the secretaries met together with the object of forming a Hospital Officers' Association. Nothing has come of this matter. It is likely that if the New Zealand hospitals were independent voluntary bodies without the government to depend upon for finances, a hospital association of some nature would have been formed long ago.

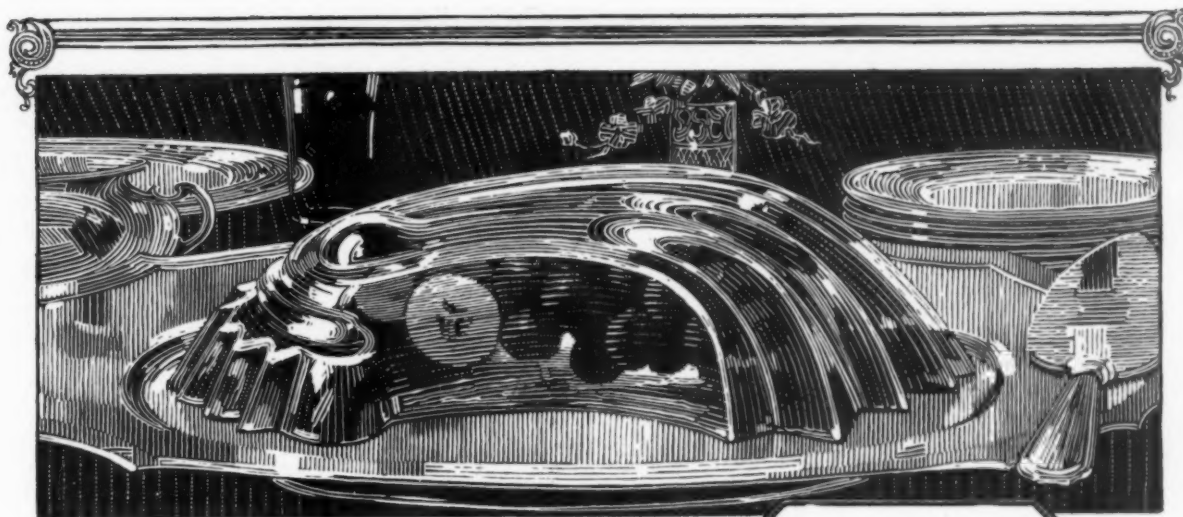
Those New Zealanders who urge the formation of a hospital association believe that the Department of Public Health, Hospitals and Charitable Aid is of more benefit as a bureau of inspection and administration, while a hospital association would be productive of valuable discussion and the circulation of literature on subjects of importance and interest regarding hospitals.

PENNSYLVANIA HOSPITALS TO ORGANIZE

The Hospital Association of Pennsylvania expects to effect a permanent organization on December 7 when a meeting will be held at the Penn-Harris Hotel in Harrisburg. The morning session will be of a business nature, with the adoption of a constitution and by-laws, the election of officers and the appointment of committees as the chief issues.

The afternoon session will consist of lectures and round table discussion with Dr. Edward Martin, state commissioner of health, and Dr. John M. Baldy, commissioner of the new welfare department of Pennsylvania, as speakers. Mr. H. E. Bishop, superintendent of the Robert Packer Hospital at Sayre, will preside.

Arrangements for the meeting are being made by a committee composed of Mr. Daniel D. Test of Pennsylvania Hospital at Philadelphia, Mr. Bishop, and Miss Victoria E. Armstrong, superintendent of the Citizens' General Hospital, at New Kensington. Mr. G. Walter Zulaud, superintendent of the Allegheny General Hospital, is chairman of the committee to prepare and submit for adoption a constitution and by-laws. The temporary chairman will be Mr. John H. Smith of the Hahnemann Hospital at Philadelphia.



Whipped Jell-O

While Jell-O with fruit as illustrated is very popular, an increasing number of users are taking advantage of the fact that it can be whipped as readily as cream. Send for a free booklet.

WHEN we originated our twenty-six ounce package of Jell-O we had in mind the same convenience that we have specialized in for the past quarter of a century. There is no weighing or fussing to contend with. Simply add the contents of the package to a gallon of boiling water. It stands for economy in time where time is costly.



Gallon Package

JELL-O

America's Most Famous Dessert

The American Offices of The Genessee Pure Food Company are at Le Roy, N. Y. The Canadian Offices are at Bridgeburg, Ont.

HOSPITAL STANDARDIZATION IS THEME OF DAY AT COLLEGE OF SURGEONS' CONGRESS

ASPECTS of hospital standardization were treated in eight interesting papers read before the Clinical Congress of the American College of Surgeons during its recent session at Philadelphia. An entire day's program, October 24, was given over to papers and to round table discussions of hospital standardization.

The round table conference conducted by Dr. Malcolm T. MacEachern, superintendent of the Vancouver General Hospital in British Columbia, had to do with staff organization, medical records, laboratories, nursing and general problems. As a central theme of the discussion was taken hospital standardization in its relation to the improvement of the professional work of the hospital and better service to the patient. Some valuable material developed in the discussion, which took the question and answer form, replies being made by some of the most experienced hospital executives, surgeons and nurses in the United States and Canada.

At the morning session Dr. George E. Armstrong of Montreal, president of the American College of Surgeons, presided.

Dr. Franklin H. Martin, secretary-general of the college, discussed at the morning session the development of its hospital standardization program during the past five years. The original purpose, according to Dr. Martin, was the betterment of surgery by establishing certain high standards for those who are admitted to fellowship in the college. To ascertain the status of applicants for fellowship, it was necessary to standardize and improve case records. The standards formulated in Washington for the use of army hospitals also had a close bearing on the standardization program of the college, he declared. Dr. Martin then brought out the progress made by the standardization campaign from 1918, when eighty nine hospitals met the standard, until this year, when 74 per cent meet the standard. The improvement of surgery was said to be inseparably linked with hospital betterment.

Dr. Robert L. Dickinson of New York spoke on "Hospital Standardization from the Viewpoint of the Medical Profession." He made a plea for a more analytical staff review, in which results are carefully scrutinized. The importance of follow-up systems was emphasized, as well as the need for more accurate statistics regarding the mortality rate and percentage of infections of various diseases and operative procedures.

A report on the hospital survey work of the college in 1921, by Dr. Frederick W. Slobe of the hospital standardization department, showed a total of 1,017 hospitals visited. Of the 761 general hospitals in the United States and Canada, having 100 or more beds capacity, 568, or 74 per cent, are on the approved list. Only 18 per cent of the approved hospitals are listed with an asterisk this

year, as compared with 47 per cent as listed last year, showing a relative decrease of the use of the asterisk. Dr. Slobe also stated that it is the hope of the college to revisit all of the smaller hospitals next year, so that they may be included in the list of approved institutions.

Dr. A. K. Haywood, superintendent of the Montreal General Hospital, in Quebec, spoke on "Hospital Standardization from the Viewpoint of the Hospital Superintendent." Dr. Haywood declared that hospital standardization is synonymous with hospital betterment. In addition to having clinical staff meetings, he emphasized the need for regular conferences of all those associated with the business administration of the hospital. The importance of autopsies was stressed also, Dr. Haywood stating that

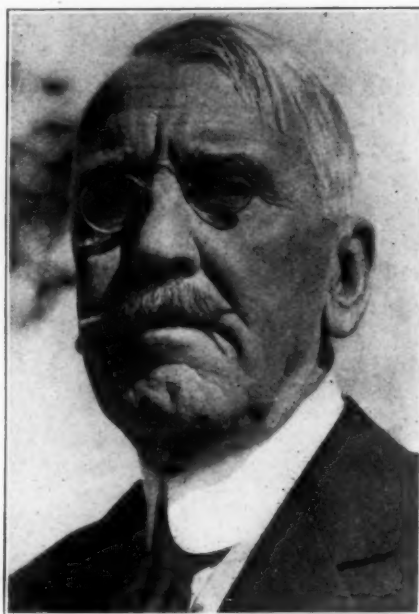
85 per cent of autopsies were obtained in the Montreal General Hospital during 1920.

Dr. Newton E. Davis, executive secretary of the conference board of hospitals and homes of the Methodist Church, spoke on "The Viewpoint of the Hospital Trustees." There is a need, he said, of educating board members to take more interest in the clinical aspect of the hospital. The program of the College, according to Dr. Davis, should appeal to business men as it gives them an accurate index to the results in the hospital. Dr. Davis is conducting a survey of sixty-five Methodist hospitals, the support of which he pledges to the program of the College.

Dr. John Baldy of Philadelphia, in his paper dwelt upon the relationship of hospital standardization to laboratory service, stating that monthly laboratory reports to the board of trustees furnish them with reliable information concerning the medical staff. In this way the

amount of laboratory tests asked for by each physician can readily be ascertained. Physicians, that use the laboratory most frequently, are more careful in their case records and diagnosis, he says, because the laboratory checks. Further, pathologists should act as consultants to the staff members, and, as such, he believes, be allowed liberties in the wards.

Rev. Fr. Charles B. Moulinier, S.J., president of the Catholic Hospital Association, stated that from a scientific viewpoint the analysis of assembled facts is the keynote of the hospital standardization program of the college. This, said he, is the era of group thinking. A sincere and frank cooperation between the staff members, a fearless search for the truth and a frank admission of mistakes constitute the bases for the improvement of the whole profession. Real analysis of results at staff meetings will automatically insure complete records and adequate laboratory work. "Hospital standardization," Father Moulinier declared, "means the standardization of the medical profession in mind, character, and heart."



John B. Deaver, M.D., of Philadelphia, president of the American College of Surgeons.

RADIUM IS WORTH ITS COST

Radium has a definite place in surgery and medicine today in the specific treatment of skin and other superficial forms of cancer, and also in conjunction with the operative treatment of cancer occurring internally. Its value in the treatment of some other common diseases has been demonstrated and proven.

MEDICAL RESEARCH SERVICE

It is the purpose of the Radium Company of Colorado to cooperate with not only those physicians who have bought radium, but also with those who would like to keep abreast of the current developments of the treatment of disease with this unique therapeutic element.

A PHYSICIAN'S REPUTATION

will be not only safeguarded but enhanced if when entering upon the practice of radium therapy he has at his command the complete and careful service which the mark below denotes.

Write our nearest office.

We can explain more intelligently this Company's complete service which only commences when the purchase of radium is made, if when writing us the physician or surgeon states in what field of work he is specializing.



The Mark of a Complete and Careful Radium Therapeutic Service



Page 710

THE RADIUM COMPANY OF COLORADO

PRINCIPAL OFFICES—LABORATORIES

RADIUM BUILDING, DENVER, COLORADO

BRANCH OFFICES

SAN FRANCISCO
582 Market St.

CHICAGO
Peoples Gas Bldg.

NEW YORK
50 Union Square

In his paper, Dr. D. Z. Dunott, chairman of the medical and surgical section of the American Railway Association, stated that 1,700,000 men were injured by railroads in the past ten years, 100,000 of these being killed. His committee has endorsed the minimum standard of the College and recommends that railroad employees, except in emergencies, be treated in hospitals meeting the minimum standard.

Favors Industrial Field

Dr. Edward Martin, commissioner of health of the State of Pennsylvania, declared in his address that the problems of industrial hospitals are those of civil life and that industrial medicine and surgery are deserving of the best minds in the medical profession. Doctor Martin deprecated, in general, the system of full-time men in industrial work.

In the discussion of Doctor Martin's paper by Dr. W. O. Sherman, chief surgeon of the Carnegie Steel Company, Pittsburgh, it was stated that 125,000 accidental deaths occurred annually and that thirty-three per cent of compensation cases require consultation of further treatment from various specialists. A plea was made for the standardization of various forms of surgical treatment and the need for greater use and equipment for electro-, physio- or hydro-therapeutic departments.

Dr. John B. Lowman of Johnstown, Pa., dwelt upon the need of more adequate supervision in the dispensaries of industrial institutions. Dr. M. M. Seymour, commissioner of health of Saskatchewan, Canada, told the Congress that in Saskatchewan, with a population of 850,000, the public is being educated as to the necessity of hospitals. According to the law in Saskatchewan, hospitals are built by taxation. Their provincial hospital association has officially adopted the minimum standard of the College.

Dr. Malcolm T. MacEachern, superintendent of the Vancouver General Hospital of Vancouver, British Columbia, in a general summary of hospital standardization, said statistics show that hospital standardization has lowered the death rate, has decreased the number of operations, infections and complications, and has lessened the duration of the patients' stay in the hospital. Hospitals have developed a new sense of responsibility to the community, he declared. Boards of directors are now being furnished with monthly reports, which give a medical audit as well as a financial audit. People are asking which hospitals in a community are standardized. Municipal authorities in certain instances have based their grants of money upon the development of standardization in the hospitals. Hospital standardization results in a direct economic gain to the community.

ROUND TABLE CONFERENCE

The following answers to important questions placed before the Congress at the various sections of its round table conference were given by surgeons of note:

STAFF ORGANIZATION

Q. Many hospitals find difficulty in formulating staff by-laws, rules and regulations for the guidance of the professional work therein. How can the College give them greater assistance? Can they secure a set of standard by-laws, rules and regulations setting forth the principles involved which shall guide them in drafting their own?

A. (By Dr. Frederick W. Slobe, on the staff of the American College of Surgeons). Sample staff by-laws, rules and regulations can be obtained by writing the American College of Surgeons headquarters at 40 East Erie Street, Chicago. In this office there are samples from numerous hospitals throughout the United States and Canada and from these can be built by-laws, rules and regulations to meet the special needs of any hospital. Several samples are available for distribution

at this meeting. The College will be glad to supply any one with this information.

Q. Many hospitals require the attending doctors to sign a pledge or card, the latter often being known as the "Physician's Registration Card." Has this been found beneficial? What is the best form to use?

A. (By Dr. Slobe). In some communities where fee-splitting is practiced more or less widely, it is found advisable to sign a pledge or card prohibiting same, but, generally speaking, it is more desirable that each member of the staff of the hospital should subscribe his name to the by-laws, rules and regulations as drafted. These by-laws, rules and regulations should contain all the essential principles of hospital standardization.

Q. In certain instances the attending doctors of hospitals have been found lacking in clinical interest. What can be done to stimulate more interest in such cases?

A. (By Dr. Frank D. Jennings, of Brooklyn, New York.) The staff conference as recommended in the program of hospital standardization has been found the greatest stimulus to clinical interest amongst the professional group attending the hospital. These conferences should be arranged at regular intervals and with definite and interesting agenda. They will result in better acquaintance, better cooperation and more increased clinical interest.

Q. How often should the staff conference be held and what is the best form for it to take, a luncheon, a dinner or an evening meeting? What should constitute the agenda for such a meeting?

A. (By Dr. Jennings.) The staff conference in hospitals takes various forms; in some a luncheon, others a dinner, or others an evening meeting. So far as known, very successful meetings have been held with or without luncheon or dinner, and it is not considered that this latter feature of something to eat influences the meeting much. An evening meeting will afford more time for discussion of the work of the hospital. The agenda for such a meeting should be, first, a review of the professional work of the hospital during the month, especially mentioning anything of clinical interest, or of such work as did not measure up to the best results or such results as are desirable. Secondly, the detailed consideration of the following, all matter of which to be presented by the doctor in charge of the patients:

(a) Deaths during the period.

(b) Patients discharged unimproved.

(c) Infections and complications occurring in the hospital.

Thirdly, recommendations for the betterment of the professional work of the hospital.

Q. What is the best way to stimulate more consultations between members of the staff in hospitals?

A. (By John M. Smith, Superintendent, Hahnemann Hospital, Philadelphia.) Consultations between members of the hospital staff are best stimulated through staff conferences, which bring the doctors together better in the discussion of their work, collectively or otherwise.

MEDICAL RECORDS

Q. Should not every medical man be responsible for seeing that a complete history is provided for each one of his cases, whether public or private?

A. Yes. Every medical man should be responsible to see that a complete history is provided for each of his cases, whether private or public.

Q. What is the best way to secure operating room records and what should they consist of mainly?

A. (By Simon Tannenbaum, Superintendent, Jewish Hospital, Philadelphia.) Operating room records are secured in various ways. Firstly, the dictation to a competent record clerk or stenographer, preferably a nurse, if same can be secured. Secondly, by using a dictophone. Thirdly, by the surgeon or assistant writing same. The most effective method is for the surgeon to dictate the report immediately to a capable stenographer or record clerk.

Q. What is the best procedure to keep accurate records of all infections occurring post-operative?

A. (By Dr. Charles Norris, Woman's Hospital, New York City.) Some hospitals have a wound record sheet, a sample of which was shown to the conference. This wound sheet gives an accurate description and daily diary of the wound throughout. The diary on any case report should contain accurate information as to the condition of the wound and especially as to infection. The intern on service, in making his daily notes, should put this down and report the same to the senior attending surgeon on duty. He should have some simple method of collecting such data.

Q. Who should be responsible for overseeing of the medical records as to completeness and quality?

A. (By Dr. F. L. Adair, Swedish Hospital, Minneapolis.) Responsibility of overseeing the medical records as to completeness and quality should be assumed by the hospital authorities and the doctor in charge of the patient to whom the record refers. If possible, a capable medical visitor in charge of the records would be the most satisfactory, in order that he may make sure that all the data is complete and

Quality Counts; Price Counts

There's a happy meeting of both in our famous

SURGEONS' GOWNS

Reason No. 1: Quality is the foundation of our business and only first-class goods and first-class workmanship are tolerated.

Reason No. 2: Operating on a huge scale, as we do, we buy at rock-bottom prices—and sell at rock-bottom prices, then passing on our savings to the wearers of our Surgeons' Gowns and other hospital apparel.

Send Us an Order on Approval

carrying charges prepaid. Unless the garments are satisfactory—yes, more than satisfactory—both as to quality and price, you may return to us collect and that will be the end of the transaction.

It stands to reason that we would not—could not—make an offer as liberal as this were we not certain that our garments would "fill the bill" from every standpoint.



Surgeons' Gowns (SIZES:—SMALL, MEDIUM, LARGE) \$18 per doz.

No. 846—High-grade, beautifully finished garments made of heavy Indian Head Cloth; 60 in. long; long sleeves; resist chemical action and blood stains.

No. 847—Featured by dignified tailoring and all-round high character; like No. 846, will launder perfectly. Made of Pepperell Jeans or Duretta Cloth, resisting chemical action and blood stains.

No. 845—Nurses' Operating Gown of White Duretta Cloth. Per doz., \$18.

—Patients' Bed Gowns—

Exceptionally well-made gowns offering exceptional comfort. Constructed of Pepperell Cloth or Indian Head; double yoke front, wide hems and tapes in back; 36 in. long, long sleeves. Per doz., \$18.

Prices subject to change without notice

The Hospital Nurses' Uniform Mfg. Co.

CINCINNATI, OHIO

correct and he can keep close in touch with the doctor in charge of the case. Some hospitals request the attending doctor to sign the record when complete.

LABORATORIES

Q. What laboratory work should a hospital of 75-100 beds provide as a minimum service?

A. (By Dr. Malcolm T. MacEachern, Superintendent, Vancouver General Hospital, British Columbia.) The answer to this question was given in a pamphlet containing a reprint of a paper given by Dr. G. F. Strong, assistant superintendent of the Vancouver General Hospital, at the British Columbia Hospital Association, and the information of this pamphlet can be obtained through the hospital library and service bureau at 22 East Ontario Street, Chicago. Several hundred copies were distributed at this conference. This pamphlet shows the minimum and essential laboratory service necessary for every hospital and supplies the basis upon which a maximum service can be built up.

Q. A hospital wants a routine pathological service in connection with its surgery. How can such service be financed?

A. (By Dr. S. C. Davidson, Superintendent Rockford Hospital, Rockford, Ill.) The financing of a routine pathological service in connection with the surgical is best done by a flat charge, either on a daily ward charge or by an addition to the operating room fee. Though this charge applies to every patient, whether using the service or not, it seems that by virtue of such a service, the patient will be receiving all around better and more efficient care in the institution.

Q. How many hospitals are routinely putting through all the material removed in the operating room and thus checking up diagnoses?

A. (By Dr. Davidson.) A large number of hospitals are found today putting through all the material removed in the operating room and checking up diagnoses thereby. In this connection it was heartily recommended that the routine pathological laboratory service should be attached closely to the operating room department, so that the pathologist and the surgeon are close together for consultation either before or after the removal of the tumor or specimen.

Q. How can the pathologist arouse more interest in clinicians and interns along laboratory lines?

A. (By Dr. A. K. Haywood, Superintendent, Montreal General Hospital, Quebec.) The pathologist can arouse more interest in the clinicians and interns along the laboratory lines by holding regular pathological conferences at which a demonstration is made of all the specimens and tissues removed during the period since the former conference. It was also suggested that in any case for post-mortem, the intern or doctor in charge of the service should list the diagnoses before the autopsy commences and further, that due announcement be made of all autopsies so that as many men as possible could attend.

NURSING

Q. Can a hospital attain the minimum standard with what is considered an incompetent nursing staff?

A. (By Dr. Charles Mayo, Rochester, Minn.) It is the general consensus of opinion that the minimum standard can not be attained in hospitals where there is an incompetent nursing staff.

Q. Can a hospital attain the minimum standard with what is considered an incompetent nursing staff?

A. (By Miss S. Lillian Clayton, Director of Nurses, Bureau of Hospital, Department of Health, Philadelphia.) Yes.

Q. Nurses' records on patients in many instances are useless. What are the essentials of such records, and how can they be made of greater use?

A. (By Miss Katherine Tucker, Superintendent Visiting Nurse Society, Philadelphia.) The essentials of nurses' notes in connection with the records assigned to this group, should be the intelligent expression of accurate observations made on the patient at frequent intervals. These observations should be more of a positive nature than negative. Particular attention should be given to describing accurately of each specimen or tissue in such manner that a full and comprehensive knowledge of the same may be obtained by the doctor when he visits the patient. In short, nurses' notes should be complete, accurate and expressed in an intelligent manner and in good style.

Q. What constitutes competent and sound applied nursing service in our hospitals today?

A. (By Miss Mary M. Riddle, Superintendent Newton Hospital, Newton Lower Falls, Mass.) Competent and sound applied nursing service today presupposes primarily a nurse with good education and mental development. On her admission to training she should have thorough instruction theoretically and practically, with close supervision over all her work. She should learn how thoroughly to do the various practical procedures in the class or demonstration room before attending the patient. The kind of service which she will render will depend a good deal on the fundamental training she is securing. Coupled with diligence in her duty that causes her to attend promptly and efficiently to all the patients' needs, so far as she is able, whether these are large or small, social or scientific, keeping in mind at all times

the best general welfare of her patient. Sound and competent nursing service to the patient means an intelligent carrying out of all routine nursing orders, of all doctors' orders for medication and treatment and particularly of anticipating the patients' needs ever by prompt attention to same.

GENERAL

Q. A hospital of 100 beds with limited funds, desires to have records and to do at least the essential x-ray and laboratory work, but cannot secure interns or afford to engage a radiographer or pathologist. How can these services be taken care of under such circumstances?

A. (By Dr. MacEachern.) This question may be answered by reference to the pamphlet referred to in question No. 1 on laboratories. Some large hospitals, and especially the Vancouver General Hospital of Vancouver, British Columbia, have established a ten months' course for graduate nurses to acquire technical skill in case recording, x-ray and laboratory work. The graduate nurse spends two months in the records department, acquiring the knowledge necessary in the handling of records; four months in the x-ray department for routine purposes; and her final four months in the laboratory, acquiring technical skill in doing the routine laboratory work necessary in hospitals. By this triple course, she is able to carry on this technical work, which is so essential in every institution. It presupposes, however, the cooperation of the medical men attending and team work between the large and small hospital laboratories.

Q. Should operative cases, other than emergency, be in the hospital for a period before operation? What routine preanesthesia examination and laboratory work should be done on each case?

A. (By Dr. MacEachern.) Operative cases should be in the hospital at least ten to twenty-four hours before operation. Indeed, there are several types of cases which should be in longer for careful observation and more intricate examination previous to operation. Every case, except of an emergency type, should have a history completely written up before operation. Special examination should be made before the anesthesia is given to determine the patient's condition to stand same, as well as to determine the kind of anesthesia best to use. In every case routine urinalysis should be done before operation and in children nose and throat swabs taken to eliminate diphtheria carriers.

Q. How can the Board of Trustees be impressed more thoroughly with the crucial importance of the patient rather than the financial aspect of the hospital?

A. (By Dr. MacEachern.) The Board of Trustees at the hospital can be influenced to take more interest in the professional work of the hospital if they are supplied with a monthly report of the same. Some hospital superintendents provide the Board of Trustees with a report somewhat as follows: Firstly, the amount of work done during the month; secondly, the physical assets of the institution, patients discharged well, patients discharged improved; thirdly, the physical liabilities, deaths during the month, infections during the month, discharged unimproved during the month; fourthly, the number of consultations held, this to include laboratory tests, x-ray examinations, etc.

Q. Have hospitals found fewer operations, less incompetent and irregular surgery, and fewer deaths, since hospital standardization has been developed and promoted?

A. Investigations made (a) on specific professional cases; (b) on hospital service, whether administrative or scientific. From such a monthly report the board can have a proper balance sheet, formulated in their minds for considering the physical report as against the financial report of the institution. Hospitals which have adopted the minimum requirements are unanimous in stating that there is less incompetent and irregular surgery done and that there are fewer patients since hospital standardization has been begun. This is due to better diagnosis, better working out of cases and proper investigation of results by staff conferences and other meetings. Two prominent hospitals have submitted interesting statistics on this matter. Both of these institutions give a comparison before and after hospital standardization and on the same basis, the number and type of cases.

In hospital No. 1, before standardization the percentage of patients operated upon is 57 and 65 per cent, but since standardization has been reduced to 40 and 47 per cent. The death rate in the same institution before standardization, exclusive of influenza and tuberculosis, was between 41 to 46 per cent per thousand and since standardization ranges between 23 and 28 per cent per thousand. Hospital No. 2, before standardization, shows that 44 per cent of the patients underwent operation, and since standardization, 30.5 per cent. The death rate before standardization was 35 per cent per thousand and has been reduced to 24 per cent per thousand. It is interesting to note two operations that were performed during this period. The number of curettages before standardization were 4.2 per cent and since standardization have been reduced to 2.7 per cent. Likewise, the number of appendectomies before standardization were 12.3 per cent and since standardization have been reduced to 7.6 per cent. Another interesting fact which some hospitals claim is that with improved efficiency in the scientific side of the hospital, the patient's days stay has been

Price Reduction Crescent Dish Washer Model "M"

\$395

A large capacity machine, at a low price

More Model "M" Crescent Electric Dish Washers have been sold during 1921 than all other models combined.

Increased production, therefore, following a wide popularity, makes it possible to reduce the price of the Model "M" from \$435.00 to \$395.00 f. o. b. factory.

One year ago this month, the Model "M" was put on the market. It had been specially designed and built in answer to a wide demand from dealer and customer alike. Diet kitchens, small schools, restaurants, hotels, Y. M. C. A.'s had long been in need of a machine of the Model "M" size and capacity.

Immediate results proved that we had made no mistake.

The Model "M" is the ideal machine for the small kitchen. Because of its ingenious three-door arrangement it is the only machine which can be placed in a corner or against the wall. It is but two feet square, yet has a washing capacity of 2000 dishes an hour.

Write for your copy of the attractive folder entitled—"The Small Dish Washer You Have Been Waiting For"

ASK YOUR KITCHEN OUTFITTER ABOUT THE CRESCENT

or talk to the Hardware Dealer, Electrical Supply Dealer, Heating and Plumbing Dealer, Central Station (Heat, Light and Power Company) in your city... and tell them you want to know more about the Crescent Electric Dish Washer.

THERE IS A CRESCENT FOR EVERY SIZE KITCHEN

Model "M"	\$395—capacity 2000 pieces per hour
Model "AA"	\$523—capacity 3000 pieces per hour
Model "EE"	\$908—capacity 5500 pieces per hour

CRESCENT WASHING MACHINE COMPANY

80 Beechwood Ave. New Rochelle, N. Y.



reduced considerably. Hospital No. 2 before standardization shows that 15.1 per cent was the average days' stay per patient, but since standardization has been reduced to 13.8 per cent.

Q. What is the best follow-up system for patients discharged from the hospital to ascertain whether the hospital is functioning efficiently in every respect?

A. Hospitals find several follow-up systems successful. Most of the follow-up work done in hospitals is done through the social service departments. By appointment, patients discharged from the institution

are re-called on a certain date for further examination by the chief of the service, or one of the assistants. A careful follow-up record is made. When no response is secured from correspondence, personal visits by the social service nurse often brings the patient. Probably there is no better way than this, or to have some officer obligated to arrange for the return of cases discharged at stated periods for further examination, all of which to be carefully recorded by the hospital with the other records of the patients and thus carry on a thoroughly well organized follow-up system.

REGINA IS HOST TO THREE HOSPITAL ASSOCIATIONS OF WESTERN CANADA

THE Western Canada Hospital Association is made up of hospitals from the four western provinces of Canada, namely,—Manitoba, Saskatchewan, Alberta and British Columbia. Representatives from each province meet annually in one or other of the provinces in turn, during the same week as the local or provincial hospital association meets. This year the conference was held in Regina, on the two days preceding the Saskatchewan Hospital Association and Western Canada Catholic Hospital Association conventions. The programs of the three conventions covered four days and evenings, making a real hospital week for Regina and the province.

The Western Canada association was organized primarily to advance hospital standardization or betterment of service, and also, as far as possible, to coordinate hospital policies and activities in the four rapidly growing and developing provinces where the question of the care of the sick is regarded with great interest and importance.

The president of this association since its beginning has been Dr. M. M. Seymour, commissioner of public health for the Province of Saskatchewan, who has been chiefly instrumental in the introduction and development of the municipal hospital system in Saskatchewan.

The program was made up of able addresses by Dr. A. K. Haywood, superintendent of the Montreal General Hospital; Dr. George Stephens, superintendent of the Winnipeg General Hospital; and Dr. M. T. MacEachern, superintendent of the Vancouver General Hospital, as well as many other authorities on all phases of hospital work.

Delegates Widely Entertained

The delegates were entertained during the convention by many persons and organizations in Regina, including Lieut.-Gov. Newlands and Miss Newlands, the provincial government, the municipal council, the medical association, the hospitals and others, at receptions, luncheons and motor drives. Throughout the entire meetings a splendid spirit prevailed.

Possibly the most interesting session was the public meeting held Tuesday evening, November 1, at which the two main speakers were Dr. M. T. MacEachern of Vancouver and Dr. A. K. Haywood of Montreal, the former speaking on hospital standardization and its effects on service to the patient, and the latter on the responsibility of the community to the hospital. Both these addresses held the interest and close attention of the audience for more than two hours.

Dr. MacEachern gave in detail a complete history of the movement of standardization and its influence on hospital service through more efficient and accurate diagnosis. He brought out that the better working out of cases, better diagnoses and more intelligently applied treatment combined with thorough check-up and review analysis of the hospital work, would result in: Lower death rate in hospitals; reduced number of operations; fewer post-operative infections and complications, and lessened days' stay of patients in hospital. He indicated how this movement is being accepted with satisfaction by all groups interested or connected with hospital work, including the administrative staff, attending medical staff, board of trustees and others, and that governmental and municipal bodies are now becoming interested in the institutions that comply with these requirements. He ended his address by an appeal to all the citizens to take an intelligent and enthusiastic interest in the work carried on by the movement.

The Hospital As An Educator

Dr. Haywood, in his address on the community's responsibility to the hospital, reviewed in an interesting manner the difficulties experienced by the Montreal General Hospital in securing sufficient finances to carry on the work. In recent years drastic measures have had to be taken in order to arouse the community's recognition of its responsibility to support this admirable work, he declared. The speaker emphasized the need of means of hospital support other than that of philanthropy and



Delegates to the Western Canada Hospital Association

KELLOGG'S BRAN

cooked and krumbled

*is invaluable as an
aid in speeding the
recovery of patients.
Use it generously.*



What a treat there is in store for patients as well as the nurse if they have cookies, muffins or raisin bread or drop cakes with Kellogg's Bran, cooked and krumbled, added for its nut-like flavor—and for its natural action as a preventive and as a permanent relief from constipation. And bran griddle cakes—well, just try them some of these snappy mornings!

Kellogg's Bran, cooked and krumbled, is wonderful—as a nature-food and for its regulatory value. It must not be confused with common brans which are flat and unpalatable. Kellogg's Bran is supremely delicious any way you eat it—as a cereal, with other cereals or in foods.

When you know from personal observation what the use of Kellogg's Bran will do for your patients and for yourself, you will be astounded! But—use it consistently—for that is the way to get permanent relief! At least two tablespoonfuls of bran should be eaten daily—for extreme cases eat it with every meal.

We particularly recommend Kellogg's Bran for bed-ridden cases. It can be used to the greatest advantage.

Kellogg's

BRAN MUFFINS

$\frac{1}{4}$ cup sugar; shortening size of an egg. Cream shortening and sugar together. Add to this—1 egg, 1 cup sour milk (or sweet milk), 1 cup Kellogg's Bran, $1\frac{1}{4}$ cups flour, 1 level teaspoon soda (or two teaspoons of baking powder if sweet milk is used), pinch of salt. Mix well. This will make one dozen muffins.

Kellogg's

*Look for
this signature
W. K. Kellogg*

the original BRAN - cooked and krumbled

Consult the 1920 Year Book for Catalog information.

endowments, both of which are becoming exhausted and inadequate to meet the demands of the time. One of the most urgent responsibilities of the community towards the hospital at present is to recognize its need of more financial support from all classes, he stated.

Dr. George Stephens of Winnipeg gave a very interesting address on the hospital's responsibility to the community. The hospital's first function, he said, is to care for the sick and bring them back to health in the quickest, most competent and comfortable manner. The second function is that of teaching doctors, nurses, the patients and the public. The hospital's function as a teacher and educator of the community may be more or less incipient and not recognized, he declared, but is a great factor in public health propaganda. Its third function is to afford research in medical science, he believes.

May Learn from the Military

Lieut.-Col. H. F. Munroe of Saskatoon, a man with extensive experience in military hospital administration, in an address referred to several features of military hospital administration which may be applied with advantage to civil institutions. He stressed as a most important point a clear definition of authority, duties and responsibilities. There should be organization from above down, he believes, so that responsibility can always be placed.

Dr. M. R. Bow, superintendent of the Regina General Hospital, spoke on the coordination of hospital service to produce efficiency. It is to the benefit of superintendent and staff to get together in round table conference regularly to discuss the affairs of the institution, he brought out. Dr. J. G. A. Scroggy of Kerrobert, Sask., outlined a plan for the administration of a small hospital, calling attention to the importance and real value to the community of a small institution. In the administration of the small hospital several services must be combined and grouped under individuals, he declared, which later, as the institution grows, can be segregated. Small hospitals in Saskatchewan are developing along standard lines and are filling a most useful function in their respective communities, Dr. Scroggy declared.

Another well prepared paper was that by Dr. W. A. Dakin, former superintendent of the Regina General Hospital, on "The Hospital and the Press." The press is of great value to the hospital in giving publicity to its work and in educating the public to its true perspective, he declared. He pointed out the need of always being frank and open with the press, and of giving to the newspapers all the information that is possible and ethical to release. The press can be a cooperative institution of great value to any hospital and in turn do the community good by education which it can disseminate, said Dr. Dakin.

Dr. R. G. Ferguson, superintendent of the Saskatchewan Sanitarium, Fort Qu'Appelle, comprehensively set forth in his paper the importance of good morale in the hospital staff. This can only be established by good organization, good living conditions, and good treatment, he asserted. By giving the staff information about the institution, by holding round table conferences, by establishing through several means a spirit of personal pride in their hospital, morale can be greatly advanced.

The keynote of the entire convention was the desire on the part of all for betterment of service to the patient and for obtaining increased hospital interest from all groups. The week will undoubtedly be one of the greatest means of stimulating hospital interest in Regina and Saskatchewan.

At the close of the convention a business meeting was held and the usual routine carried out. Dr. George Stephens, superintendent of Winnipeg General Hospital, was selected as the next president, and Dr. Warren A. Panton of Regina, secretary. The meeting of 1922 will be held in Winnipeg.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION IS NEW NAME

The Baltimore convention of the American Occupational Therapy Association in October was a great success. There were some 220 registered, and the members hailed from many states. Naturally, those from the south and the districts about Baltimore, were most numerous. Active working aides were, as usual, in the majority, but this year saw more doctors present than ever before.

Perhaps the most important business transacted was that connected with the new constitution, which was adopted with very few dissenting votes. Members of the old board of managers, who drafted the numerous amendments, believe that the business of the association will be expedited and that there will be at the same time a much more representative government. The actual conduct of business is now in the hands of two persons, who with the president are answerable to the new House of Delegates, which this year has twenty-two members elected from eight state societies.

The change of name from the cumbersome National Society for the Promotion of Occupational Therapy to the crisper and quite as descriptive American Occupational Therapy Association is certainly an improvement. A.O.T.A., then, are our own official letters for the present, and probably for always.

The meeting at the Phipps Psychiatric Clinic was the high point of the convention with stirring addresses by Dr. Adolph Myers, Mrs. Eleanor Clarke Slagle and Mr. Louis J. Haas. The afternoon meeting at the Sheppard and Enoch Pratt Hospital at Towson deserves special mention. Members were taken out to Towson in Public Health Service motors, and a delicious out of door luncheon was served by the hospital in advance of the round table conference which occupied the rest of the day. Two dances and a vaudeville show gave more than usual gaiety to the meeting. This feature, or something like it, will doubtless be carried out again, as most of our members are young and ready to enjoy the social opportunities as well as the more serious business of the conventions. The exhibition of crafts work was exceptionally good and included this year a showing of models worked out and recommended by the aides themselves or by professional designers and craftsmen. There was also a commercial exhibit showing all sorts of material and equipment for occupational therapy.

Too much credit cannot be given to Dr. W. B. Dunton and his assistants, who were responsible for the excellent arrangements at the Southern Hotel and elsewhere.

The officers and committees elected were as follows:—

President, Dr. Herbert J. Hall; vice-president, Dr. G. Canby Robinson; secretary-treasurer, Mrs. Eleanor Clarke Slagle.

Board of Management: Mrs. Cornelius J. Sullivan and Mrs. Carl Henry Davis.

In some small hospitals, even yet, the superintendent is expected to do everything from the managing of the hospital and the training school to the stoking of fires in winter if the fireman fails to appear.

Learn about this Remarkable New Insecticide

*Free Trial Offer
to Hospitals*



NEVER BEFORE in the history of the insecticide business has a new product met with such instant, wide-spread appreciation.

Since its development, as a war aid to sanitation, Flyosan has been adopted by various United States Government departments, many Boards of Health in the larger cities, the Y. M. C. A. and leading hospitals, hotels and restaurant systems throughout the country.

Flyosan makes easy the removal of pediculae from a patient's garments or person. Beds and bedding can be rid of bedbugs without the trouble of fumigation.

Hundreds of leading hospitals, institutions and industrial firms are already using Flyosan. They find it excellent for ridding clothing and bedding of parasites. It keeps store rooms free from moths and clears kitchens of cockroaches. In the Navy it is used for spraying the seats of toilets.

Flyosan is a clear amber liquid which is converted into a gas by an ordinary garden sprayer.

Flyosan kills all sorts of bugs and insects. It is effective against flies, mosquitoes, bedbugs, cockroaches, waterbugs, moths, ants, lice, gnats, fleas, etc.

It is easy to use. You can spray it anywhere.

Flyosan brings bugs out of hiding, then kills them. You can tell when you have finished the job.

To make it easy for hospitals to learn the outstanding merits of this new product, we are, for a limited time, making a free trial offer. We will send to any responsible party connected with a hospital or similar institution a free trial package containing a pint can of Flyosan and a sprayer. The only condition is that you write us on the letter head of your institution and give in addition to your name your title or function.

Write Department A for the sample package.

Price \$4 a Gallon

Special prices in larger quantities

Flyosan

INSECT EXTERMINATOR

COLONIAL CHEMICAL CORPORATION, READING, PA.

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR.

Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, and Chief, Service Bureau on Dispensaries and Community Relations of Hospitals, American Hospital Association, 15 W. 43rd Street, New York

THE DEVELOPMENT OF THE DENTAL CLINIC IN HOSPITALS AND DISPENSARIES

BY MICHAEL M. DAVIS, JR., PH.D., NEW YORK

DENTAL clinics have been developed of four types:

1. In connection with industrial or commercial establishments.
2. In connection with hospitals and dispensaries.
3. As public health clinics:
 - a. In public schools.
 - b. Independent local clinics.
 - c. Dental institutions founded as part of a community dental program.
4. In connection with hospitals and dispensaries.

Only a brief mention in this article can be made of types 1, 2, and 3.

1. *The dental infirmary* (of the dental college) has had a limited range of community service. The demands of dental practice have been largely for curative work, and the service of the dental infirmary connected with the dental college had been primarily to give the student opportunities for practice in various forms of curative work, chiefly in adults.

Industrial Dental Clinics

2. *Industrial plants*, coming to a realization of the importance of sound teeth to health and efficiency, have in many instances installed a dental clinic. Some seventy-two plants in the United States are known to have taken this step. Sometimes the expense is borne entirely by the firm, and sometimes the employees pay for the cost of materials. Some firms offer only emergency treatment, and send the employee to private dentists for further care; other require the employee to have his teeth put in order and offer him the service of the clinic. The firms that have installed dental service are invariably enthusiastic about its benefits both to the health and to the self-respect of the employees.

Dental Work in Schools

3. *Public Health Dental Clinics*. The dental clinic established primarily for the purpose of meeting community dental needs is a very recent development. These public health dental clinics are not merely those which have been established in public schools or in special dental institu-

tions particularly for preventive work and for children; the public interest has also led to the establishment of many dental clinics in general dispensaries and under independent auspices. The public health movement has taken hold of the dental clinic because of recognition that adequate dental care for the community cannot be furnished as an adjunct to private dental practice, and is in large measure a public project which must be handled by public and semi-public agencies.

Dental clinics in the public schools have been developed considerably in the United States and in some European countries, but are as yet in their infancy compared with the need. A number of social settlements and philanthropic organizations, feeling acutely the need of their clients for dental service, have established small clinics in neighborhood houses or health centers. Large institutions have been especially established as public health measures in Rochester (The Rochester Dental Dispensary), and in Boston (The Forsyth Dental Infirmary).

4. *Dental Service in Hospitals and Dispensaries*. The growing recognition of the connection between dentistry and medicine has been manifested in many ways, among them the increase in dental service in general hospitals and dispensaries. Dental work or dental diagnosis in the general hospital was practically unknown a few years ago.

Inquiries were sent during the course of this survey to 282 general hospitals, including almost all those in the United States of 100 beds or over. One hundred and forty-four replies, or 51 per cent, were received, a rather high average of replies to questionnaires of this sort.

The following questions were asked:

1. Do you have a dental service in connection with your hospital?

2. If so, is this a dental service with rank as a hospital department and ward beds assigned, or is it merely diagnostic in character?

3. Is there also a dental clinic in your out-patient department, in which treatments are given, and if so, what is the size and scope of such clinic?

4. Do you feel the need of a dental service, either therapeutic or diagnostic, in your hospital or your out-patient department, if you have not already developed it and what policy do you think a hospital should pursue in this matter?

Eighty-nine of the 144 replies reported dental services

*This is a portion of a report on dental needs and dental facilities in a number of selected cities and medical institutions throughout the country, prepared by the Service Bureau on Dispensary and Community Relations of Hospitals of the American Hospital Association, at the request of Mr. Julius Rosenwald of Chicago. The complete report will shortly be published in book form.

WE take this opportunity to announce to hospital superintendents and administrators the news that we are now in a position to furnish, in any quantity, a complete line of

HOSPITAL FURNITURE and BEDSTEADS

Our new plant, operated under personal supervision of men of long experience in the manufacture of metal furniture, enables us to stand behind the quality of our products.

Call us in to figure on your furniture requirements whether large or small.

We also handle general hospital supplies of every nature, including rubber goods, enamelware, glassware and textiles—all the products of reliable manufacturers.

J. H. BRADLEY MANUFACTURING CO.
705 N. 12th Street Philadelphia, Pa.

in the hospital; in four more a dental service was in the process of establishment; in twelve more it was being planned, and in two more it was hoped for. Thus dental service was either definitely established or well under way in more than one-third of the 282 larger general hospitals of the United States.

In 46 of these hospitals, dental service is recognized as of departmental rank, with assigned beds in some instances and in others with use of beds as needed. In 32 of the 89, dental service is not recognized as a department, but is organized for purposes of consultation and diagnosis. In 11 of the 89 hospitals, dental work includes offering dental treatment to patients but is not recognized as a general department of the hospital.

Of the 89 hospitals with dental service, 41 maintained dental work for their ward patients, but had no general dental clinic. Seventeen of the 89 hospitals had no dispensary clinics of any kind, but of the remaining 72 which had some out-patient department, 48 had a dental clinic as part thereof.

Most of these clinics were for dental treatment as well as for diagnosis, only five being limited to diagnosis only.

The great pressure for dental service is illustrated by the fact that a large number of these hospitals have found it necessary to limit their dental clinic for the use of patients referred from other parts of the hospital or dispensary.

From the answers to the general questions of our inquiry, it may be said that all the leading hospitals, as reported by their superintendents, recognized the desirability of dental service. The only question that existed was as to the details of its organization and the extent to which dental work should be carried out, owing to the expense and to the risk that the hospital or dispensary would be swamped if a dental clinic were opened up for general community purposes.

A Dentist on the Hospital Staff

On the basis of this survey and of studies of dental work in various hospitals made in connection with other surveys, certain points or principles might well be set down.

(1) A dentist competent as a dental diagnostician should be recognized with adequate rank on the staff of the hospital, and should be given the necessary facilities, such as access to the x-ray and to beds when necessary.

(2) The primary responsibility of the hospital in dental care is the dental diagnosis of patients whose mouth conditions are involved as a factor in the disease for which the hospital accepted these cases, and for whom dental treatment is necessary in order that the hospital's medical or surgical work shall attain satisfactory results. In other words, a hospital cannot carry out adequate diagnosis and treatment without undertaking dental diagnosis, and in some instances dental treatment also.

(3) A routine dental examination of hospital cases should be included as part of the physical examination.

(4) Hospitals maintaining out-patient departments should include a dental clinic for treatment purposes as part of this out-patient department, unless by some definite affiliation with another accessible dental clinic, the necessary dental care of its patients can be assured.

Hospitals Should Limit Dental Service

(5) The service of a dental clinic as part of the hospital out-patient department must ordinarily be limited in order to avoid over-crowding. Patients should be accepted for treatment in the following order:

- a. Patients already received by the hospital or dis-

pensary, whose mouth conditions are involved in a general medical or surgical condition which the hospital or dispensary has diagnosed, and for which it has assumed responsibility for treatment. To give dental care to these patients, or to arrange for their care by definite reference and follow-up to some other institution is a responsibility which every hospital ought to meet.

- b. Patients referred to the dental clinic from other medical or community agencies (such as a doctor or a visiting nursing organization) with the indication that the dental conditions are involved in the general condition of the patient.

- c. Relief of pain and other emergency dental work for patients not otherwise connected with the hospital, but accepted merely as emergency cases.

- d. Other patients accepted up to whatever number may be consistent with the facilities. So far as possible, this restriction should be on a district basis.

(6) Dental organization in the hospital.

- a. The dentist recognized as head of the dental service of the hospital should be in charge of the organization of its dental work, including the out-patient clinic.

- b. Assistant dentists are desirable as visiting members of the staff of the dental clinic.

- c. A dental intern is desirable, as a member of the staff of the hospital. His work should be confined to assisting in the therapeutic work of the out-patient department. He should also be given opportunity to work in the diagnostic service with the chief of the hospital dental department, in order that his year of internship shall be a year of advanced dental education in both curative and diagnostic work. The supply of dental interns is inadequate, but the trend of dental education will stimulate young graduates to take a hospital year, and the increasing demand for dental service in hospitals may be expected to increase also the facilities which hospitals will offer to dental graduates.

- d. The dental hygienist is a desirable member of the staff of the dental clinic, and as an agent for cleaning the teeth of bed patients in the hospital.

- e. Salaries for visiting dentists are generally necessary.

- f. The dental clinic should charge fees covering cost of treatment, remitted, however, if the patients are unable to pay.

Prophylactic Work Should Be Free

- (7) The following financial policies are reasonable in the maintenance of organized dental service:

- a. Prophylactic work for children should be free and open to all children of school ages on the same terms as is public education.

- b. With respect to the cost of this service, it should be borne in mind that the estimated cost of tooth cleaning and of instruction in mouth hygiene to children on a large scale is less than 5 per cent of the usual per capita cost of school education, and is a measure which will make more efficient the other 95 per cent expended.

- c. For dental care other than prophylaxis, a charge should be made in the clinic, including an admission fee and additional charges for materials used for fillings, anesthesia, and other purposes; these fees being remitted when necessary.



Illustration of 734-1916 Hospital and Institution Bed, with Adjustable Irrigating Standard and Head Rest.

The Modern Hospital Bed

FOR use in ward or private room, this three-piece bed has proved itself to be invaluable. Of sanitary chill-less construction, finished in white enamel and mounted on detachable wheel-casters, it is the height of perfection in hospital bed construction.

The ideal link sagless fabric that is used for the spring on this bed gives the body just the correct amount of support necessary for comfortable sleep. The headrest and irrigating standard attachments are easily attached and are most convenient.

But this is only a part of the hospital service equipment Salisbury & Satterlee have to offer you. Write us for further information on S. & S. hospital equipment. Ask for the new catalog.

SALISBURY & SATTERLEE CO.
METAL BEDS-SPRINGS-MATTRESSES
MINNEAPOLIS, MINN



Corner of Ward Showing Installation of Bryant Silent Call Hospital Signal Devices

The Patient Presses a Button

Instantly signal lights at various parts of the building show the nurses exactly where their services are wanted.

The button operates with the lightest touch but cannot function unless intentionally pushed. A call made by a patient must be answered before the signals can be erased. The patient is sure to receive attention.

No. 14 Ward Calling Station is illustrated below.



When the button is pushed a magnet operates the control switch which connects the various signal circuits. In wards a red bull's eye indicates the patient who calls. The nurse resets the switch and extinguishes the signals by pressing the resetting button.

This is the first of a series of advertisements in Modern Hospital explaining the Operation of Bryant Silent Call Hospital Signal Devices. Next month the new Pull Toggle Control Switch will be described. In the meantime, send for the 36-page catalog which explains the system in detail.

THE BRYANT ELECTRIC COMPANY

BRIDGEPORT, CONN.
NEW YORK CHICAGO SAN FRANCISCO



Page 848

HINTS TO HOSPITAL SUPERINTENDENTS

SAVING TIME IN LINEN TRANSPORTATION

Most hospitals feel that they have taken a step forward in efficiency when they establish a central linen room. But here is a further advance suggested in its elimination. The soiled linen is sent, as before, direct to the laundry, but when it has been washed, instead of being piled into baskets and taken to the linen room, there to be sorted and placed on shelves, and then transferred from the shelves to the carriers and thence to the wards, a much simpler method has been adopted. The linen is taken directly from the laundry machines to sorting shelves in the laundry, and from these shelves it is placed in baskets for the various wards and delivered to them direct. Savings are effected in time for transportation as well as in sorting and filling the orders. These last processes may be done by the head laundress, thus eliminating the position of head of the linen room.

PUT UP PLENTY OF GUIDING SIGNS

If, because your building is an old one not adapted to modern procedures, your social service department or some other department which must be visited by entering patients is only reached by devious and winding ways, see that there are plenty of guiding signs. So often bewildered patients wander about the hospital in a vain attempt to locate the department to which they were sent. They bother the personnel of the institution and wear themselves out with their efforts. Then, too, in the case of foreigners it might be well to have signs on the order of the well known English signboard, "If you can't read English, inquire here."

"LEST WE FORGET"

The remark was overheard in a hospital of very good standing, "O, that is too bad, but your nurse forgot to bring your medicine, didn't she?" Forgot? Evidently, she did. Fortunately the forgotten dose made no great difference in the welfare of the patient but suppose the nurse had forgotten the necessary hypodermic to keep the patient alive. "Forgetting" should be a criminal offense in a hospital. Not something to be mildly deplored. Military discipline is as much needed here as when the enemy is in the next trench.

Another thing noticed in the same hospital was that the nurse often had to ask the patient whether or not he had had the prescribed egg-nogg or milk that morning. It seemed that the patient was his own keeper. If he said no, someone was dispatched to get the drink though it might then be an hour or so late. There seemed to be no coordination or organization in the matter. Whose business was it to see that the patient in Room 14 had his drink at eleven? No one seemed to know, at least if they did they kept it a secret.

STUDENTS TAUGHT BY STUDENTS

Are your student nurses taught certain nursing procedures by other students? It is true that in some hospitals this method of the blind leading the blind is used to some extent. Of course the teaching staff of the school may be entirely inadequate for its work, yet this should not be an excuse for not giving at least one or two demonstrations, before the student is left to perform the service under the guidance of only another student.

FIRST IMPRESSIONS AGAIN

Perhaps you think that the "welcoming tone" of the hospital is a bit overemphasized. But it could not be, it is so very important. First impressions mean much to all of us—more than ever to the sick. Drill your attendants in the habit of looking pleasant and jumping to take the newcomers suitcase, or do some little service. Impress the clerk at the information desk with the importance of a smile accompanied by painstaking service. These things create the first impression of your hospital.

HAVE LIGHT WHICH THE PATIENT CAN ADJUST

A bedside light which the patient himself can adjust is an excellent thing in a hospital. Perhaps a standing floor lamp which may be turned in any direction or bent or straightened would be the best kind to have. To say nothing of the extra labor of the nurse, it gives the patient a helpless feeling to have to ring for someone else to turn on or adjust his light. You cannot tell how great the psychological effect of such things may be. In any case, it is worth taking into consideration.

HAVE YOU PLENTY OF SWITCHBOARD OPERATORS?

Have you ever gone out of your own hospital and anonymously called up by telephone asking for information about or to speak to one of the patients? If not it would be an illuminating experience. To the uninitiated the hospital is a place of great speed and dispatch—like a fire department—where in an emergency things can be done and had in an incredibly short time. It shatters this illusion to be kept sitting at the phone for three to five minutes waiting for the proper connection. Sometimes, quite often in fact, we have been left high and dry speaking persuasive words to an entirely deaf ear at the other end of the wire. Perhaps the operator has gone out to lunch, but she might at least have warned us that she was going. This department of the hospital seems quite often to be very short handed. Plenty of operators should be provided, and they should be carefully trained and impressed with the extreme importance of their position.



Barnes Hospital, St. Louis

WITHOUT doubt this is one of the best equipped, most up-to-date hospitals in the United States. The fact that it is equipped with Smith & Davis Hospital Furniture speaks volumes for the high character of Smith & Davis products. The endorsement of such a progressive institution is a safe guide for other hospitals and sanitariums in the selection of Hospital Beds and Cribs, Maternity Bedsteads, Bedside Tables, Screens, Irrigators, Utensil Racks, Bed Trucks, Conveyers, Stretchers, etc.

We furnish complete equipments for hospitals, sanitariums, college dormitories and similar institutions. Suggestions, blue prints and prices on request. Special price reductions on quantity orders.

Or, if you have in mind something different in beds or furniture, to be specially built according to your own specifications, we will cordially co-operate with you in its designing and production.

Steel Beds
Brass Beds
Steel Cribs
Hospital Beds
Hospital Furniture

SMITH & DAVIS
Manufacturing Company
St. Louis

Coil Springs
Link Springs
Steel Cots
Canvas Cots
Steel Couches

QUERIES AND ANSWERS

MINIMUM OF LABORATORY WORK

To the Editor of THE MODERN HOSPITAL:

What is the minimum laboratory work that every hospital should be prepared to carry on? **TECHNICIAN.**

Urinalysis, blood examinations, as white and red cell counts and hemoglobin; smears for bacteria; examination of spinal fluid; examination of stomach contents; examination of feces; preservation of tissues for pathological investigation elsewhere.

TEN MONTHS' COURSE FOR LABORATORY WORK

To the Editor of THE MODERN HOSPITAL:

Could a graduate nurse acquire sufficient knowledge and training anywhere in eight or ten months to fit her to carry on the laboratory, x-ray, and medical record work necessary for a hospital of less than one hundred beds? **GRADUATE NURSE.**

Yes, some hospitals offer such courses. For example, the Vancouver General Hospital offers a course of ten months, apportioned as follows: Medical records, two months; x-ray, four months; laboratory, four months. This would give sufficient knowledge to undertake the work in a hospital of one hundred beds or less. This course, we understand, is at present limited to candidates from British Columbia.

ROUSING INTEREST IN STANDARDIZATION

To the Editor of THE MODERN HOSPITAL:

How can we increase the interest of the profession and the community in hospital standardization?

A HOSPITAL ASSOCIATION.

Keep hospital standardization constantly before everyone in its actual application. Apply it most strictly in the hospital and use every occasion to carry it home to both the doctors and the people in the community. The placing of literature in their hands from time to time will help to get the interest worked up. One of the best methods is to have a standardization committee consisting of professional and lay members.

MONTHLY MEDICAL REPORT TO BOARD OF DIRECTORS

To the Editor of THE MODERN HOSPITAL:

Should a monthly medical report be sent to the board of directors or trustees and, if so, of what should it consist? **CHIEF OF STAFF.**

Yes. A monthly report to the board of directors or trustees should be sent and should indicate the following:

- (a) Volume of work done during the month in each department.
- (b) Results obtained.
- (c) Special consideration of:
 - (1) Unimproved,
 - (2) Deaths,
 - (3) Infections or untoward results.
- (d) Investigations made:
 - (1) Professional care of patients,
 - (2) Administration problems and complaints.
- (e) Recommendations.

CONNECTION BETWEEN STERILIZING AND OPERATING ROOM

To the Editor of THE MODERN HOSPITAL:

Should a sterilizing room be connected directly with the operating room? **A SURGEON.**

A direct connection between sterilizing room and operating room is not advisable because the steam from the sterilizing room affects the instruments and creates a condensation on the walls of the operating room which is difficult to remove.

SHOULD THE STAFF LIVE OUTSIDE THE HOSPITAL?

To the Editor of THE MODERN HOSPITAL:

Should the staff, other than nurses, live in or out of the hospital, and which is the most economical for the hospital? **BOARD OF TRUSTEES.**

Some hospitals find it more desirable to have all their staff, other than nurses, live out side of the hospital, thus relieving them of a great deal of extra equipment and trouble. However, it is generally conceded that it is more economical to keep the entire staff living in. This is impossible in many hospitals, owing to lack of accommodation.

CREAM OR BUFF SHADE BEST COLOR FOR HOSPITALS

To the Editor of THE MODERN HOSPITAL:

What is the most desirable color scheme for walls and ceilings in a hospital? **ARCHITECT.**

The most desirable color scheme for walls and ceilings in a hospital appears to be a cream or buff shade or light green. In places where there are many dark or rainy days the light buff or cream for walls and ceilings is the most generally used.

VISITING HOURS FOR WAGE EARNER

To the Editor of THE MODERN HOSPITAL:

Is it just to the head and wage earner of a family to be excluded from the hospital because he cannot call during visiting hours? **SUPERINTENDENT OF NURSES.**

It is hardly fair that the wage earner should not be allowed to visit members of his family when his business prevents him from observing regular visiting hours. In some hospitals a good plan is in force which allows such persons to come two evenings each week, possibly between 7 and 7:30.

THE DIAGNOSIS OF SYPHILIS

in its Primary Stage is Essential for an Immediate Cure

In the early stages of the disease, Wassermann tests are not always positive and they must be supplemented by microscopic examinations. The most simple and easy method of microscopic examination is with an up-to-date microscope fitted with a sub-stage dark-field illuminator. We recommend two improved types of these instruments.

The U. S. Army Medical School Model Dark-Field Illuminator was designed in cooperation with Major G. B. Foster, Jr., and other officers of the Medical Corp at the U. S. Army Medical School to obtain a compact instrument independent of accessory lamps with which difficulty is usually experienced in getting the proper illumination. This has been accomplished by mounting a low voltage Mazda lamp and condensing lens in a telescoping sleeve on the under side of the usual substage dark-field. This construction facilitates the exact focusing of the beam of light for properly illuminating the system. Centering screws are provided for aligning the lamp and dark-field with the axis of the optical system of the microscope on which it is used. A diaphragm is provided for use with a 1.8 mm oil-immersion objective. The necessary electric current for the Mazda lamp may be obtained either from dry batteries, storage batteries or from the lighting circuit by using a resistance. When ordering give the name of the maker, type and number of the microscope on which the dark-field will be used.

8645. ILLUMINATOR, Dark-field, as described above. Complete with diaphragm for oil-immersion objective, lamp cord, Edison socket and extra 6 volt Mazda lamp, in plush lined wooden case\$35.00

8646. RESISTANCE, to reduce lighting voltage A.C. or D.C. to 6 volts:

No.	A.	C.B.
For volts	110	220
Each	\$6.00	\$8.00

The Spencer 44H Microscope is a microscope well adapted to meet the requirements of hospital and general medical laboratories and is especially recommended for use with the No. 8645 Dark-Field Illuminator. It is a very strong but graceful microscope, fitted with a patented side fine adjustment possessing many exclusive features. The principle feature is the construction of the solid steel fine adjustment screw, which has 20 of its 34 threads engaged even at the limit of its motion. This construction distributes the wear, lengthens the life of the most vital part of the instrument and enables the operator to work with an ease not obtained with other types of fine adjustment. The direction in focusing is the same with both the fine and coarse adjustments. One revolution moves the tube 0.2mm. The body tube is standard, taking standard objectives and oculars. The stage is 112x108mm, and is completely covered with genuine vulcanite rubber, vulcanized directly to the stage plate. The sub-stage is of the standard quick-screw form.

8532. MICROSCOPE, Spencer 44H, as described above. Complete with standard body tube, triple nose-piece, three objectives, including a 1.8mm oil-immersion, two oculars, N. A. 1.20 Abbe condenser mounted in the quick-screw form sub-stage, and a hardwood cabinet with lock and key.....\$132.00

A ten per cent discount will be allowed to all Hospitals or Educational Institutions on the above equipment.

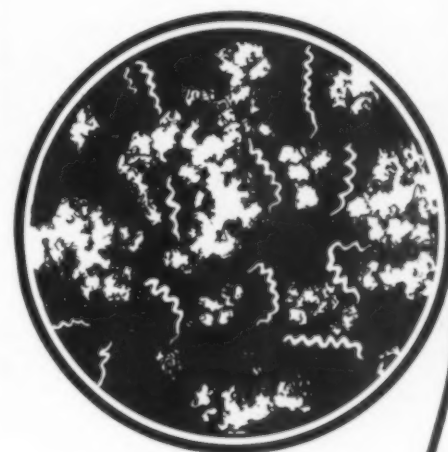
For further information on the above items write for bulletins No. 32MH, 96MH, and 96AMH.

CENTRAL SCIENTIFIC COMPANY

LABORATORY APPARATUS SUPPLIES
460 E. Ohio St. Chicago, Ill. U.S.A.



Page 397



Consult the 1920 Year Book for Catalog information.

BOOK REVIEWS AND CURRENT HOSPITAL LITERATURE

A PRIMER FOR DIABETIC PATIENTS

By Russell M. Wilder, Ph.D., M.D.; Mary A. Foley, Dietitian; and Daisy Ellithorpe, Dietitian, The Mayo Clinic.¹

Dr. Russell Wilder and two dietitians, Mary Foley and Daisy Ellithorpe of the Mayo Clinic, have prepared this Primer for their patients. The material in mimeographed form has been used successfully at the Mayo Clinic for some time. It has been printed in book form in order to more satisfactorily meet the demand for it. This Primer was designed for use as a supplement to Dr. Joslin's Diabetic Manual, the instruction being given in more detail. For example, the chapters on Weights and Measures, Food as Energy, and Urine Testing explain, as well as state facts in such a way that the patient with no information on these subjects can easily follow them. A good selection of menus and recipes is given, with discussion of some food materials used.

REVIEW OF THE YEAR-BOOK

The American Year Book of Anesthesia and Analgesia, 1917-1918. (Copyrighted January, 1921.) F. H. McMechan, M.D., Editor. Large Quarto, Bound in Art Buckram and Printed on Natural Tint Paper, 471 Text Pages, 175 Illustrations. Containing a Cumulative Index of the Pertinent Literature for 1917-1918 and Contributions by 84 Eminent Authorities.²

The American Year Book of Anesthesia and Analgesia, covering the advances in these subjects during 1917-1918, is just at hand in its de luxe format, making as much of a typographical as a scientific appeal. Delayed in publication by the World War, it contains those methods of anesthesia and analgesia introduced to expedite military surgery, which are to find a place for themselves in civilian practise for the benefit of all concerned.

Again the editor of the Year Book has tried to make it appeal to all the progressive members of the allied professions and specialties who, in any way, are vitally interested in current advances in the science and art of anesthesia and analgesia.

The Year Book, as a cumulative encyclopedia, provides the anesthetist, specialist, surgeon, dentist, research worker, and hospital superintendent with those special advances that meet their individual requirements.

Fundamental studies in the pharmaco-physiopathology of anesthesia and analgesia, of exceptional merit, have been included, and as many of them have a direct bearing on the clinical handling of patients submitting to operations under narcosis, they are doubly significant and valuable.

All pertinent phases of the science and practice of anesthesia and analgesia during 1917-1918 have been covered in collated papers and researches from the most promi-

nent international authorities, and the Year Book is again a comprehensive and exhaustive postgraduate course. To those interested it is not a luxury but an everyday necessity as a reference volume.

Aside from series of contributions on complicating and safety factors of anesthesia, acidosis, blood changes, blood pressure variations, pharmaco-physiopathological studies both in general and local anesthesia, methods of technic, especially those developed in war surgery and the newer methods of local analgesia in surgery, dentistry, and the specialties, the Year Book contains a cumulative index of the pertinent literature for 1917-1918, which is invaluable to anyone making a study of any phases of these subjects and needing the necessary bibliography for reference or teaching.

EATING TO LIVE LONG

By William Henry Porter, M.D. 243 pages.¹

Seldom have we seen a book containing so much that is commendable and so much that we cannot commend combined in one small volume. The title of the book and the headings of each chapter would indicate that a subject of very general interest is discussed in a popular way, and to a great extent this is true, though there is considerable material included in various chapters which is evidently written for the physician. Yet a great deal of this material is not in accord with the more widely accepted belief of today. Dr. Porter condemns the use of fruit, especially at meal time, and advocates more liberal use of meat, a practice which would meet the approval of only a small minority of medical men and nutrition workers; he decries the use of oatmeal because only a small percentage of it is used by the body, in another chapter he speaks of the need of "roughage" in the diet. Many good sound principles are advocated in forceful language, it is to be regretted that the force of the text is lessened by what would seem to be an opportunity for the author to rebel against the prevalent teachings in nutrition and dietotherapy.

An appeal to school children in all parts of the United States to build chairs and tables to be used in re-equipping the schools in the devastated areas of France and Belgium has been issued by the Junior Department of the Red Cross. French schools are handicapped by a deplorable shortage of equipment that cannot be purchased in France. An organization has been formed in France through which schools outside the devastated area have adopted schools in the war zone, for the purpose of providing equipment, but so far only half the schools have been taken care of.

1. W. B. Saunders Company, Philadelphia, Pa.
2. Surgery Publishing Co., 15 East 26th St., New York City.

1. The Reilly and Lee Co., Chicago.

